MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

01773

Reg. Diat. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Ashton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

no street number

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Ashton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: none

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: SARAH THOMAS M. ADAMS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband ~~or wife~~: Herbert S. Adams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 17, 1865

8. AGE: Years	Months	Days	If less than one day
81	3	24	..... hrs. ..... min.

9. Birthplace: Montgomery County, Maryland

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Wm. W. Moore

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary E. Thomas

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Mary E. S. Bently

Address: Ashton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1947 (month) (day) (year)

Cemetery or crematory: Meeting House Cemetery

Location: Sandy Spring, Maryland

18. Funeral director: W. Reuben Thomas

Address: 7557 Wisconsin Ave., Beth., Md.

19. 2-11-1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11, 1947, at 5:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/2/1946, to 2/11/1947

and that I last saw h[illegible] alive on 2/10/1947

Immediate cause of death	DURATION
Uraemia	4 days
Due to: Chronic Interstitial Nephritis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work? —

23. SIGNATURE: [signature] M. D.

Address: Sandy Spring, Md. Date signed: 2/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01774

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D C
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2106 "R" St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John L. Apple

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Eve
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1861.

8. AGE: Years	Months	Days	If less than one day
85	2	26	hrs. min.

9. Birthplace: Indiana Co., Pa. (Town, county, and state)
10. Usual occupation: Retired govt worker
11. Industry or business:
FATHER 12. Name: Alexander K. Apple
13. Birthplace: Penn.
MOTHER 14. Maiden name: Evelyn Jamison
15. Birthplace: Penn
16. Informant: Hospital records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/6/47 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cem.
Location:
18. Funeral director: S. J. Miller Co
Address: 2401 14th St NW
19. Feb 3 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3, 1947, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Jan 47 to Feb 3 1947.
and that I last saw him alive on Feb 3 1947.

Immediate cause of death	DURATION
a Carcinoma stomach &	6 + mo?
metastasis to colon +	
Due to Peritonitis	
b Obstruction lower sigmoid	1 wk + ?
Due to colon from tumor mass	
Other conditions with rupture bowell above obstruction and secondary generalized peritonitis.	1 day

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: given above, per Dr Bullard
PHYSICIAN: Please underline the cause to which death should be charged (tabulation).

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. H. Richwine MD. M. D. or other
Address: 5522 Western Ave Chevy Chase 15, Md. Date signed: Feb 4 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01775

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Jan. 3, 1947

Hospital, Institution, or street address where death occurred:
Suburban Hosp. — Bethesda - Md.

How long in hospital or institution? Since Jan. 3, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. #3
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Mr John S. Atwood

3. (b) Social Security Number None

4. Sex: M

5. Color or race: W.

6.(a) Single, married, widowed, or ~~divorced~~

6.(b) Name of husband or wife Minnie I. Atwood (Dec)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6, 1864

8. AGE: Years 82 | Months 7 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Montrose, Maryland
(Town, county, and state)

10. Usual occupation Farmer (retired)

11. Industry or business

FATHER
12. Name William Atwood
13. Birthplace Montrose, Maryland

MOTHER
14. Maiden name Anna Greenfield
15. Birthplace Montrose, Maryland

16. Informant Mr. Clarence Atwood
Address Gaithersburg, Md. R.F.D. # 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/13/47 (month) (day) (year)

Cemetery or crematory St. Marys Catholic Cemetery

Location Rockville, Maryland

18. Funeral director Wm Reuben Dumphrey

Address 7557 Wis. Ave. Bethesda, Maryland

19. 2/12 (Date rec'd by registrar) 1947 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1947 at 8:15AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1946 to February 10 1947

and that I last saw him alive on February 9 1947

Immediate cause of death	DURATION
Respiratory Failure.	
Due to Pulmonary Congestion	
Due to Cardio vascular renal disease (Arteriosclerotic)	
Other conditions Auricular premature Jubillation.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank Joggerst M.D. M. D. or other

Address 8016 Rockville Pk. Date signed 2/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 01776 31

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7329 Piney Br. Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7329 Piney Br Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES DWIGHT AVERY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myra Chapman Avery
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29, 1877

8. AGE: Years: 69 Months: 6 Days: 8 If less than one day: hrs. min.

9. Birthplace: Galesville, Md.
(Town, county, and state)

10. Usual occupation: Geologist.

11. Industry or business: U. S. Government.

FATHER
12. Name: Henry A. Avery
13. Birthplace: N. Y.

MOTHER
14. Maiden name: Catharine Fowler
15. Birthplace: Newburgh, N. Y.

16. Informant: Mrs. Myra Avery
Address: 7329 Piney Br. Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 4, 47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Wash. Balto. Blvd.

18. Funeral director: The S. P. Hines Co.
Address: Washington, D. C.

19. Feb 1st 1947 (Date rec'd by registrar) E. Widley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 February 1947, at 4 47 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 January 1947, to 1 Feb. 1947 and that I last saw h[illegible] alive on 1 February 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	12 hrs.
Due to Coronary Thrombosis	23 days
Due to Arteriosclerotic Vascular Disease	years
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: G B Leuba M.D.
M. D. or other
Address: Takoma Park, Md. Date signed: 1 Feb. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-2230- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9320)

CERTIFICATE OF DEATH

019011

Reg. Dist. No. 7146

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? from 9/18/41
Hospital, Institution, or street address where death occurred:
Cedarcroft Sanitarium
How long in hospital or institution? from 9/18/41

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 712 Wayne Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: NETTIE R. BAINS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Robert Lee Bains
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 9 1866

8. AGE: Years	Months	Days	If less than one day
81	0	1	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: housewife (formerly)
11. Industry or business

FATHER
12. Name: Benjamin H. Steinmetz
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Irene Wardell
15. Birthplace: Maryland

16. Informant: Robert S. Bains (son)
Address: 712 Wayne Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-13-1947 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Washington, D. C.

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Feb 17 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1947, at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/18 1941 to 2/10 1947 and that I last saw her alive on 2/10 1947

Immediate cause of death	DURATION
Myocarditis	over 5 years
Due to:	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. B. Tschudy M. D. (M. D. or other)
Address: Cedarcroft Sanitarium Date signed: 2/10 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01777

Reg. Dist. No. 2130

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Grandin Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Meyden Park

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Diana Fay Baker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1946 ?

8. AGE:

Years	Months	Days	If less than one day
1	1	14	____ hrs. ____ min.

9. Birthplace: Montg. Co. General Hosp. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Walter M. Baker

13. Birthplace: Darnestown, Md

MOTHER

14. Maiden name: Cecelia Fay Barr

15. Birthplace: Long Brook, Pa.

16. Informant: Walter M. Baker

Address: Grandin ave. Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-17-47 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem.

Location: Rockville, Md

18. Funeral director: Wm Reuben Dunphy

Address: Rockville, Md.

19. 2-17 19 47 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1947 at 1.20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1947, to Feb. 15 1947 and that I last saw h[illegible] alive on Feb. 15 1947

	DURATION
Immediate cause of death	
Bronchopneumonia	2 days
Due to —	
Due to —	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op. —

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. G. Smithson M.D. M. D. or other

Address: Rockville, Md. Date signed 2/15/47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01778

(170-C)

Reg. Dist. No. MV 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, Institution, or street address where death occurred: Washington Sanatorium & Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8119 Georgia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: John T. Barnes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Margaret Barnes

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 26 1870

8. AGE: Years	Months	Days	If less than one day
76	1	10	..... hrs. ..... min.

9. Birthplace: Monty. Co. Md

(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Retired from soldiers home

FATHER

12. Name: James Barnes

13. Birthplace: Monty Co Md

MOTHER

14. Maiden name: Mary Ellen Davis

15. Birthplace: Monty Co Md

16. Informant: Hospital records

Address: Takoma Park Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof FEB - 8 - 1947 (month) (day) (year)

Cemetery or crematory: COLESVILLE METHODIST CHURCH.

Location: COLESVILLE - MONTG. CO. MD.

18. Funeral director: Warner E. Pumphrey

Address: SILVER SPRING - MD.

19. Feb 7th 1947 (Date rec'd by registrar)

W. Dudley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 1947 at 1:11 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dep. Med. Exam 19.. to .. 19..

and that I last saw h.. alive on .. 19..

Immediate cause of death	DURATION
Pulmonary edema	8 days
Due to: pneumonia	
Due to: Fracture L. left femur (accidental)	18 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Means or stone

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1-18-47

Where did injury occur? Silver Spring (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) street

Means of injury Auto Injured at work? No

23. SIGNATURE: Dep. Med. Exam. Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg Md Date signed 2-6-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25

2-2230-1-10

STATE OF MARYLAND—CERTIFICATE OF DEATH

01779

1. PLACE OF DEATH (94a)

County Mont a — Registration Dist. No. 2110

Village or City Damascus — R.F.D. #1 Germantown — St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 0 yrs. 9 mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs. Minnie Carriere Bedford — If veteran, specify WAR —

(a) Residence: No. R.F.D. #1 Germantown St., Ward Damascus Md (Rural)

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Albert H. Bedford

6. DATE OF BIRTH (month, day, and year) Feb. 3 1872.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	0	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Housekeeping

10. Date deceased last worked at this occupation (month and year) 12 yrs. — 11. Total time (years) spent in this occupation 12 yrs

12. BIRTHPLACE (city or town) Baltimore (State or country) Md

FATHER

13. NAME Chas. Carriere

14. BIRTHPLACE (city or town) Germantown (State or country)

MOTHER

15. MAIDEN NAME Caroline Seahl

16. BIRTHPLACE (city or town) Baltimore (State or country) Md

17. INFORMANT Edwin Steedle (Address) 3630 - 13th St. N.E. D.C.

18. BURIAL, CREMATION, OR REMOVAL Place Prospect Hill Cemetery Date Feb. 17, 1947

19. UNDERTAKER Watson N. Hendersmann (Address) 5732 Ga. Ave.

20. FILED Feb. 15, 1947 Della M. Burdette Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 15 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1930, to Feb 15, 1947

I last saw h-e alive on Feb. 12, 1947; death is said to have occurred on the date stated above, at 3:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute Coronary occlusion	3 hrs
Due to General arteriosclerosis	10 yrs
Edema	
Other Contributory Causes of Importance: Senility	

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of Injury —

24. Was disease or injury in any way related to occupation of deceased? —

If so, specify

(Signed) Walter J. Thomas M. D.

(Address) Damascus Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, c. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

1-3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

9-30-1780

MV Reg. Diat. No. 2160

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8620 Garfield St.
(If rural, give LOCATION)
2.(a) Ll veteran, name war: World War II

3.(a) FULL NAME: John Clark Bell

3.(b) Social Security Number: 579-26-3202

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 4, 1924.

8. AGE: Years: 22 | Months: 6 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Rockville, Md. (Town, county, and State)
10. Usual occupation: student
11. Industry or business: George Washington University

FATHER
12. Name: George E. Bell
13. Birthplace: Rockville, Md.

MOTHER
14. Maiden name: Gertrude Ward
15. Birthplace: Rockville, Md.

16. Informant: Mrs. Gertrude W. Bell
Address: 8620 Garfield St., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/13/47 (month) (day) (year)
Cemetery or crematory: Potomac Church Cemetery
Location: Potomac, Maryland

18. Funeral director: Wm. Reaman Humphreys
Address: Bethesda, Maryland

19. 2/12 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb-10, 1947, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 9 1946 to Feb 10 1947 and that I last saw h alive on Feb 10 1947. Autopsy

	DURATION
Immediate cause of death: Compound comminuted fracture of r temporal bone	3 days
Due to: accidental	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Reserved above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 2-7-47
Where did injury occur? Rockville (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto Injured at work? no

23. SIGNATURE: Frank J. Brockhurst M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed: 2-11-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13Pa)

CERTIFICATE OF DEATH

C1781

★ Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 46 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1314 Lewis St. N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Samuel Phillips Belt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Nellie C. Belt

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 28, 1881

8. AGE: Years	Months	Days	If less than one day
65	8	10	..... hrs. ..... min.

9. Birthplace: Leesburg - Virginia
(Town, county, and state)

10. Usual occupation: Retired Engineer.

11. Industry or business

FATHER 12. Name: Not obtained.

FATHER 13. Birthplace

MOTHER 14. Maiden name

MOTHER 15. Birthplace

16. Informant: Washington Sanitarium Records

Address

17. Burial, cremation, or removal. Which? Burial Date thereof: 2/7/47 (month) (day) (year)

Cemetery or crematory

Location: Leesburg Virginia

18. Funeral director: J. William Lee's Sons

Address: 300-4th St. N.E. Washington, D.C.

19. Feb. 7 1947 (Date rec'd by registrar) J. Wm. Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 7 1947 at 1:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1946 to Feb 7 1947 and that I last saw h.. alive on Feb 6 1947

	DURATION
Immediate cause of death: Uremia	unknown
congestive failure	
Due to: chr nephritis	unknown
Due to: Hypertensive cardiac disease	unknown
Other conditions: arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Fenton J. Audley M.D. or other

Address: 1252 16th St. Date signed: Feb 9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35-

01782

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164B)

CERTIFICATE OF DEATH

Reg. Dist. No. 2165

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Columbia Country Club Grounds
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 12 W. Blackthorn St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ROLAND AUBREY BOGLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace Roberds Bogley
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): October 12, 1900

8. AGE: Years	Months	Days	If less than one day
46	3	29	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Lawyer
11. Industry or business

FATHER
12. Name: John William Bogley
13. Birthplace: Rockville, Maryland

MOTHER
14. Maiden name: Annie R. Fletcher
15. Birthplace: Washington, D. C.

16. Informant: Mrs. Grace Bogley
Address: Chevy Chase, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/14/47 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm Reuben Dunphrey
Address: 7557 Wis. Ave. Bethesda, Maryland

19. 2/13 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11, 1947, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Dep. Med. Exam. Case	Died Suddenly
Asphyxia	
Due to: drowning	
suicide	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 2-11-47
Where did injury occur? Chevy Chase (City or town) Monty (County) Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Bouchant M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed: 2/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 345.7

2-35

01783

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 2140

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
714 Spring Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 714 Spring Street
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME IONE SHAW BOWLING

3.(b) Social Security Number 577-01-1809

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband XXX James Bowling
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 11th. 1887

8. AGE: Years	Months	Days	If less than one day
60	1	15	..... hrs. ..... min.

9. Birthplace Montg. Co. Md.
(Town, county, and state)
10. Usual occupation Retired Clerk
11. Industry or business Telephone Company

FATHER
12. Name John H. Shaw
13. Birthplace Maryland

MOTHER
14. Maiden name Julia A. Riggs
15. Birthplace Montg. Co. Md.

16. Informant Mrs. Hallie L. Bramell
Address 714 Spring St. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-28-1947 (month) (day) (year)
Cemetery or crematory XXXXX Rockville Union
Location Rockville, Montg. Co. Md.

18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.

19. Feb. 26 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1947, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1938, to Feb 26 1947
and that I last saw h cr alive on Feb 24 1947

Immediate cause of death	DURATION
I Metastatic carcinoma	5 yrs
Due to Carcinoma left breast	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E. E. Pumphrey M.D. M. D. or other
Address 1822 Belmont St. N.W. Washington D.C. Date signed 2/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1822 Baltimore
Md. & E Georgia.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

01784

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on admission
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? dead on admission

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1637 Mass. Ave., NW, Wash., D. C
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3. (a) FULL NAME: BROWN, James Henry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored C-US	married

6.(b) Name of husband or wife: Mary Lee Brown
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): 1 March 1912

8. AGE: Years	Months	Days	If less than one day
34	11	18	hrs. min.

9. Birthplace: Bennettsville, S. Carolina
(Town, county, and state)
10. Usual occupation: Building Superintendent
11. Industry or business: Nat. Jewish Welfare Board

FATHER
12. Name: Sam Brown
13. Birthplace: unknown

MOTHER
14. Maiden name: Dolly Anna Brown
15. Birthplace: S. Carolina

16. Informant: Mrs. Mary Lee Brown
Address: 1637 Mass. Ave. NW, Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-20-47 (month) (day) (year)
Cemetery or crematory: St. Lukes Cemetery
Location: Hasty, N.C.
18. Funeral director: Ernest W. Jarvis
Address: 1432 U St., N.W., Wash., D.C.

19. 2-20 19 47 (Date rec'd by registrar)
Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 February 19 47 at 1:23 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Lobar Pneumonia, left lower lobe — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockett M.D. Dep. med. Examr. M. D. or other
Address: Gaithersburg md Date signed 2-19-47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

2VS A15 9-45-15M

2/24/47

2-25

2 — 2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

01785

Reg. Dist. No. 2170

1. PLACE OF DEATH:

County Montgomery

City or town Brinklow (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Montgomery

City or town Brinklow (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lorenza T. Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1901

8. AGE: Years	Months	Days	If less than one day
46	1	2	hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER — 12. Name John E. Brown

13. Birthplace Md.

MOTHER — 14. Maiden name Mary M. Thomas

15. Birthplace Md.

16. Informant Mary Amanda Brown

Address Box 51, Brinklow, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1947 (month) (day) (year)

Cemetery or crematory Ebenezer Cemetery

Location Ashton, Maryland

18. Funeral director R. F. Snowden

Address Rockville, Md.

19. March 5 1947 Gertrude B Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1947, at 9:a P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med Exam 19 , to 19

and that I last saw h alive on 19

Immediate cause of death Drowning (accidental)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION: Found dead in river 3/3/47

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of D-21-47

Where did injury occur? Brinklow (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Drowning

Means of injury in River Injured at work? No

23. SIGNATURE Frank J. Bynhart M.D. Official Exam M. D. or other

Address Gaithersburg Md Date signed 3-4-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Mrs

Z-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01785

Reg. Dist. No. 414

Montg.

1. PLACE OF DEATH:
County 708 Elgin Av.
City or town Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1209 Emerson St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME M. Elizabeth Buckingham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15. 1864

8. AGE: Years 82 | Months | Days | If less than one day hrs. min.

9. Birthplace New Liberty Md (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Benjamin Buckingham

13. Birthplace New Liberty - Md

MOTHER 14. Maiden name Hannah Duddear

15. Birthplace new liberty md.

16. Informant Mrs. Richard W. Neeley

Address 1209 Emerson st. N.W.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 8. 47 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington D.C.

18. Funeral director Deal Funeral Home

Address 4812 Georgia Ave. N.W. D.C.

19. Feb 5 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1947 at 1 30 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 1, 1947, to Feb 5, 1947 and that I last saw h.C.r. alive on Feb 1, 1947

	DURATION
Immediate cause of death Coronary Heart Disease	10 years
Due to Arteriosclerosis	40 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel A. Killman M. D. or other
Address 249 Missouri Ave NW Date signed 2-5-47
Wash DC.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

708. Neighbor.
Dr. Hillman
Buckingham Ph. 6040

1-35

Evidence for the addition of change of age is shown on G 108 2/14/47

01787

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1. PLACE OF DEATH: No. 6709 Street, Takoma Park Md. Section

Name of Hospital Home Duration of residence therein

2. FULL NAME Bessie Burrell

(a) Residence, No. 6709 Street Takoma Park Md.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in D. of C., Md 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F | 4. COLOR OR RACE: Col. | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5A. If married, widowed or divorced, HUSBAND of (or) WIFE of Emmett H Burrell

6. DATE OF BIRTH (month, day, and year) Dec 25 1869

7. AGE: Years 77 | Months | Days | If LESS than 1 day hrs. or min.

8. OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Leesburg Va
(State or country)

PARENTS

10. NAME OF FATHER (in full) — Gardner
11. BIRTHPLACE OF FATHER: City or town Leesburg Va
State or country
12. MAIDEN NAME OF MOTHER (in full) — Gardner
13. BIRTHPLACE OF MOTHER: City or town Leesburg Va
State or country

14. Above information furnished by Mrs. Andrew
Address 6709 Poplar Ave Takoma Park Md

15. Relation of informant to decedent Daughter

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) Feb 10 1947

17. I HEREBY CERTIFY, that I attended deceased from Feb 3 1947, to Feb 10 1947, that I last saw h... alive on Feb 7 1947, and that death occurred, on the date stated above, at 8:10 a. m. The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Endocarditis

(duration) yrs. 10 mos. ds.

18. Where was disease contracted if not at place of death?

Name of Operation Date

Was there an autopsy? No

What laboratory test confirmed diagnosis?

(Signed) H. Hillman M. D.

(Address) 1612 19th St. D.C.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Washington DC | DATE 19...

20. UNDERTAKER Ralph Barbour

Address Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Form 7 H. D. C. 9—1474

copy sent to county registrar

2/11/47

death of the deceased, the name of said deceased and the location of the body or part thereof.

SEC. 683. That it shall be unlawful for any person or persons to cremate or otherwise destroy the dead body, or part of the dead body, of any human being in said District before the issue of the burial permit by the health officer of said District, and then only when said permit is countersigned by the coroner of said District authorizing such cremation or destruction. It shall be unlawful for any person or persons to embalm, inject, or, by any similar method preserve the dead body or part of the dead body of any human being in said District within four hours after death or before the issue of the death certificate; and in case the death is believed to be due to other than natural causes, or the cause thereof is unknown, such embalming, injecting or preserving shall at no time be done unless such death certificate has been signed or approved by the coroner of said District.

OFFICE HOURS.—The Health Department is open for the issuance of burial permits, the receipt of complaints, and the transaction of any urgent business, from 9 o'clock a. m. until 11 o'clock p. m., daily.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01788

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Gaudes Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Gaudes ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: INFANT MARGARET L. BUTT Butt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 14, 1947

8. AGE:

Years	Months	Days	If less than one day
	2	4	hrs. min.

9. Birthplace: Montg. Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: John F. Butt
13. Birthplace: Montg. Co. Maryland

MOTHER
14. Maiden name: Margaret M. Harker
15. Birthplace: Prince Geo. Co. Md.

16. Informant: Mrs. Margaret M. Butt
Address: Rockville, Maryland (Mother)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/20/47 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland
18. Funeral director: Wm. Loudon Dempsey
Address: Rockville, Maryland

19. 2-20 1947 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1947, at 12 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 1947, to Feb. 18 1947, and that I last saw her alive on February 18 1947.

Immediate cause of death: Bronchopneumonia — DURATION: 1 day.

Due to, or as a consequence of: This child died about 6 hours after being found by mother cyanosed & comatose, with head under bed cover. On admission Temp. T of 102° with rales in chest. Clinically it was a pneumonia death.

Other conditions: Asphyxiating or possible atelectasis. Thymico-lymphatic may have been factors.

(Include pregnancy within 3 months of death)

Major findings of operations: none

Autopsy (Were Coroner consulted?) Date of op. none

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. R. Smithson M.D.
M. D. or other
Address: Rockville, Md. Date signed: 2/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

★ 01789

Reg. Diat. No. 216/

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 3-45-15M

3/18/47

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
USNaval Hospital, Bethesda, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2020 19th Place, S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James John CADY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 February 1947

8. AGE: Years	Months	Days	If less than one day
		1	11 hrs. 23 min.

9. Birthplace Bethesda, Montgomery, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Patrick William Cady

13. Birthplace Mass.

MOTHER 14. Maiden name Florence Mary Boyle

15. Birthplace Mass.

16. Informant Mo: Mrs. Florence Mary Cady

Address 2020 19th Place, S.E., Wash., D.C

17. burial Date thereof 2-4-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory George Washington Memorial

Location Hyattsville, Md.

18. Funeral director W. W. CHAMBERS

Address 1400 Chapin St., N.W. Wash., D.C.

19. 2-2 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 February 19 47 at 5:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 February 19 47, to 2 Feb. 19 47 and that I last saw him alive on 2 February 19 47

Immediate cause of death Respiratory Failure — DURATION

Due to Prematurity and Anemia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE PAUL PETERSON, Capt. (MC.) USN
M. D. or other

Address USNH Bethesda, Md. Date signed 2-2-47

2-25

2-2160 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01790

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 3 hrs 40 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Calvert Co.
City or town Lusby
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wilson A. Carroll

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1857

8. AGE: Years	Months	Days	If less than one day
89	11	27	hrs. min.

9. Birthplace Johnstown, Pa. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Hospital Records
Address Takoma Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 11, 1947. (month) (day) (year)
Cemetery or crematory Smithsburg Cemetery.
Location Smithsburg, Md.

18. Funeral director Arthur G. Fellers
Address 7th & Carroll St. N.W., Takoma Park, D.C.

19. Feb. 8 1947 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947, at 9:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1 1941, to February 8 1947 and that I last saw him alive on February 8 1947

Immediate cause of death	DURATION
Pulmonary edema	1 hr.
Due to Severe Coronary Sclerosis	several years
Due to with Acute heart failure	24 hrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. McNeill M.D. M. D. or other
Address Silver Spring, Md Date signed 2/9/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (752)

CERTIFICATE OF DEATH

01791

Reg. Dist. No. 7140

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs.
Hospital, institution, or street address where death occurred:
9516 Colesville Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9516 Colesville Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Russell Castell, Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

B.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30 1932

8. AGE: Years 14 | Months 6 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Wash. D.C
(Town, county, and state)

10. Usual occupation school boy

11. Industry or business —

FATHER
12. Name Geo. R. Castell
13. Birthplace Wash D.C

MOTHER
14. Maiden name Gertrude M. Conner
15. Birthplace Wash. D.C.

18. Informant Geo R. Castell
Address 9516 Colesville Rd. Silver Spring Md

17. Burial — Date thereof Feb 15 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Washington D.C.

18. Funeral director James T Ryan Inc
Address 317 Pa Ave S.E.

19. Feb 13 1947 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to 19..
and that I last saw alive on Feb 12 1947

Immediate cause of death — DURATION
Acute cardiac dilatation — Instantly
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bronhart M.D.
M. D. or other
Address Gaithersburg Md Date signed 2-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 11793 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days.

Hospital, Institution, or street address where death occurred: Washington Sanitarium & Hosp.

How long in hospital or institution? 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: —

City or town: Washington.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 19th st. N.W. All States Hotel

(If rural, give LOCATION) 5 24.

2.(a) If veteran, name war: —

3.(a) FULL NAME: Miss Maude Cavender

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Jan. 3 1885

8. AGE:

Years	Months	Days	If less than one day
62	0	7	... hrs. ... min.

9. Birthplace: Rutland Indiana. (Town, county, and state)

10. Usual occupation: Retired Gov't. Clerk

11. Industry or business:

FATHER

12. Name: William Cavender

13. Birthplace: unknown.

MOTHER

14. Maiden name: Fannie Whistler

15. Birthplace: Pennsylvania.

16. Informant: Records - Washington San. & Hosp.

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 10 1947 (month) (day) (year)

Cemetery or crematory:

Location: Leiters Ford Md.

18. Funeral director: J. William Lee Sons Co.

Address: 300 - 4 St N.E. Wash. D.C.

19. Feb 13 1947 (Date rec'd by registrar) J. William Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 19 47, at 6 42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1946 19.. to Feb. 10 1947 and that I last saw h[er] alive on Feb. 9 1947

Immediate cause of death	DURATION
Acute Uremia	7 days
Due to: Blockage of ureters from Carcinoma of uterus	3 yrs.
Due to:	
Other conditions: Extensive metastasis of carcinoma (Include pregnancy within 3 months of death)	" " (?)

Major findings of operations: Hysterectomy for carcinoma of uterus — Date of op. 10/8/46

Autopsy results: ... Obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: John F. Broomfield M.D. M.D. or other

Address: Takoma Park — Date signed: 2/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

0179352

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Cabin John
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Joseph C. Claghorn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Constance
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1869.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	5	8		

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: John W. Claghorn
13. Birthplace: Phila - Pa.
MOTHER 14. Maiden name: Louise Conover
15. Birthplace: Phila - Pa -
16. Informant: wife
Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/14/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Maryland
18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda, Maryland

19. 2/13/47 (Date rec'd by registrar) 1947 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12, 1947, at 7 20 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 14 1946 to Feb 12 1947
and that I last saw him alive on Feb 12 1947
Immediate cause of death: Epithelioma face with metastases to cervical and cranial

DURATION
3 yrs

Due to: metastases structures.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. Massie Fay M.D.
M. D. or other
Address: 1150 Conn. Ave. Wash. D.C. Date signed: 2-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01794

Reg. Dist. No. 2140

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Usual~~ street address where death occurred:
9418 Wire Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9418 Wire Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: CAROLINE VIRGINIA CLARK

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Franklin Pierce
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 22nd. 1861

8. AGE: Years	Months	Days	If less than one day
85	11	24	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Henry Scholl
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Caroline Murphy
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Clarence J. Clements
Address: 9418 Wire Ave. Silver Spring.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-18-47 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Forest Glen, Montg. Co., Md.
18. Funeral director: Warner E Pumphrey
Address: Silver Spring, Maryland.
19. Feb. 17 1947 (Date rec'd by registrar) Josephine M Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1947, at 2:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939, to Feb. 16 1947
and that I last saw h.. alive on Feb. 16 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	3 hrs.
Due to: Generalized Arteriosclerosis	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: W B Wardrop M.D. M. D. or other
Address: 943 Bonifant St. Silver Spring Md. Date signed: 2/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01795

Reg. Dist. No. 21 81

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Florence L. Clark

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife David W. Clark

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May 18 1877

8. AGE: Years	Months	Days	If less than one day
69	8	18	hrs. min.

8. Birthplace Maryland (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Home
FATHER 12. Name William R Griffith
13. Birthplace Maryland
MOTHER 14. Maiden name Isabella Griffith
15. Birthplace Maryland
18. Informant David W. Clark
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 6 1947 (month) (day) (year)
Cemetery or crematory Gaithersburg Md
Location Montgomery Co Md
18. Funeral director Roy H Barber
Address Gaithersburg Md
19. 2/6 1947 (Date rec'd by registrar) L. D. Dale Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 47, at 2 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 19 47, to Feb 4 19 47
and that I last saw h alive on Feb 1st 19 47

	DURATION
Immediate cause of death Thrombosis of Coronary, Arteries	Short duration
Due to Sclerosis of the Coronary Arteries	Indefinite
Due to Arteriosclerosis	Indefinite
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Vernon H Dryden M.D. M. D. or other
Address Gaithersburg Md Date signed Feb 5 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

01796

CERTIFICATE OF DEATH

Reg. Diat. No. 211 0

1. PLACE OF DEATH:
County Montgomery
City or town Rural Damascus Dist
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rural Damascus Dist
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph W Clay

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married

6.(b) Name of husband or wife Grace V Clay
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 6 - 1871

8. AGE:

Years	Months	Days	If less than one day
75	4	27	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farm

FATHER
12. Name Adolphus Clay
13. Birthplace Maryland

MOTHER
14. Maiden name Isabell Phillips
15. Birthplace Maryland

16. Informant Grace V. Clay
Address Damascus Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-1947 (month) (day) (year)
Cemetery or crematory Damascus Md
Location Montgomery Co Md

18. Funeral director Roy W Barber
Address Laytonsville Md

19. Feb 3 19 47 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 19 47, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 46, to February 2 19 47
and that I last saw him alive on January 16, 19 47

Immediate cause of death	DURATION
Arteriosclerotic cardiac vascular disease	10 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ....Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James D. Kerr M.D.
M. D. or other
Address Damascus, Md. Date signed 2/3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-0)

CERTIFICATE OF DEATH

★ 01797

Reg. Dist. No. 2130

1. PLACE OF DEATH:
County: Montgomery
City or town: R.F.D., Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
Glen Road
How long in hospital or Institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No.: none
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: EMMA IRENE CROSS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: Reginald Cross
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): August 31, 1876

8. AGE:

Years	Months	Days	If less than one day
70	3	23	....hrs. ....min.

9. Birthplace: Montgomery County, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: none

FATHER
12. Name: John Whalen
13. Birthplace: Montgomery Co., Md.

MOTHER
14. Maiden name: Frances Collier
15. Birthplace: Dickerson, Md.

16. Informant: Mrs. Thomas Stearn (daughter)
Address: Glen Rd., R.F.D., Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof ....(month) (day) (year)
Cemetery or crematory: Monocacy Cemetery
Location: Beallsville, Maryland

18. Funeral director: Wm. Reardon Pumphrey
Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 2-25 (Date rec'd by registrar) 19 47 Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 19 47 at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

	DURATION
Immediate cause of death: Dep. Med. Exam. Case	
Acute Myocarditis	Died
Due to:	Suddenly
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bernhart M.D. M. D. or other
Address: Gaithersburg, Maryland Date signed: 2/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-1)

01798

CERTIFICATE OF DEATH

Reg. Dist. No. 2140

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 17 days
Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 1 month, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New Jersey County: Union
City or town: Plain Field
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Corner 5th & Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Miss Marion Cunningham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 7-8-1872

8. AGE: Years	Months	Days	If less than one day
74	7	5	6 hrs. 5 min.

9. Birthplace: Philadelphia, Pennsylvania (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Samuel Cunningham
13. Birthplace: Philadelphia Pa.

MOTHER
14. Maiden name: Annie Mallock
15. Birthplace: Philadelphia Pa.

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb 17, 1947 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Westfield, N.J.

18. Funeral director: Joseph Daniels, Inc.
Address: 456 Lenox Ave, N.Y.C.

19. Feb 14 1947 (Date rec'd by registrar) Josephine M. Schaeffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14, 1947, at 6:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9th 1947, to Feb 14th 1947 and that I last saw h.. alive on Feb. 13th 1947

Immediate cause of death	DURATION
General carcinomatosis	
Abdomen —	6 wks.
Due to: (Primary lesion not known)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: as above
Date of op.: 1-9-47
Autopsy results: as above —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Brendzel M.D. (M. D. or other)
Address: Takoma Park — Date signed: 2-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

01799

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred:
Washington San. & Hosp.
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Huntingdon
City or town: Huntingdon
(If outside city or town limits, write RURAL and give nearest town)
Street No. 314 9th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Lola Daughenbaugh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Mr. Irvin M. Daughenbaugh
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): Jan 9, 1882

8. AGE: Years: 65 Months: Days: 28 If less than one day: ...hrs. ...min.

9. Birthplace: Oakland Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Mr. William F. Rotte
13. Birthplace: Oakland, Md.

MOTHER
14. Maiden name: Clara Russell
15. Birthplace: Oakland, Md.

16. Informant: Mrs. Mary F. Rotte (sister)
Address: 603 Flower Ave. Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1947. (month) (day) (year)
Cemetery or crematory:
Location: HUNTINGDON, PENNA.
18. Funeral director: Arthur Bakers
Address: 254 Grant St. Takoma Park, D.C.
19. Feb 7, 1947 (Date rec'd by registrar) Wm. Rotte Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6, 1947, at 10:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16, 1947, to Feb 6, 1947, and that I last saw h.. alive on Feb. 6, 1947.

Immediate cause of death	DURATION
Uremia	
Hypertension And Arteriosclerotic	
Cardiovascular Renal Disease	
Due to Chronic Glomerulo Nephritis	
Diabetes Mellitus	
Due to Pancreatitis Cystotitis	
Terminal pneumonia	
Other conditions Diabetic & Arteriosclerotic	
retinopathy with Edindemas + Cataracts	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Dr. Vee K. Meade M.D. (M. D. or other)
Address: Takoma Park, Md. Date signed 2-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

★ 01800

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
406 Battery Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 406 Battery Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LOUISE HOWSER DAVIS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Dr. Harry P. Davis (deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 29, 1889

8. AGE: Years	Months	Days	If less than one day
57	5	4	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Harry R. Howser
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Carrie McLaughlin
15. Birthplace: Washington, D. C.

16. Informant: Mr. Harry R. Howser Jr.
Address: 406 Battery Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6, 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D. C.

18. Funeral director: W. Reuben Thomas
Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 2/5 (Date rec'd by registrar) 1947 Mrs E Jules Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1947 at 12:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1946 to Feb 3 1947
and that I last saw her alive on Feb. 2 1947

Immediate cause of death: Carcinoma breast. — DURATION: 18 mo +

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Radical breast removal 2°. Date of op. July 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. Marie Lay M.D. M. D. or other
Address: 1150 Conn. Ave. Wash. D.C. Date signed 2-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

01801

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Fairfax
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DONELAN, William Joseph, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Anna Donelan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7, 1917

8. AGE: Years	Months	Days	If less than one day
29	7	3	hrs. min.

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER — 12. Name: William J. Donelan, Sr.
13. Birthplace: Ireland

MOTHER — 14. Maiden name: Sarah Agnes Donelan
15. Birthplace: Ireland

16. Informant: wife: Mrs. Anna Donelan
Address: Fairfax, Va., Route #1

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2-13-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: Georgetown, D. C.

19. 2-11 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 February 19 47 at 7:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 July 19 46, to 10 Feb. 19 47 and that I last saw h... im ...alive on 10 Feb. 19 47

	DURATION
Immediate cause of death: Concussion Sigmoid Colon	6 mos
Due to:	
Due to:	
Other conditions: Generalized metastases	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. S. ASHBURN, Lt. Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

2/15/47

2-25

2 — 2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

CERTIFICATE OF DEATH

9164 ★ 01802

MV Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 22 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg (If outside city or town limits, write RURAL and give nearest town)
Street No.: R. # (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Melvin R. Dyson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1926

8. AGE: Years: 20 Months: 6 Days: 21 If less than one day: hrs. min.

9. Birthplace: Gaithersburg (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Hard Dyson
FATHER — 13. Birthplace: Gaithersburg

MOTHER — 14. Maiden name: Louise Hawkins
MOTHER — 15. Birthplace: Gaithersburg.

16. Informant: Immediate Family
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 6 1947 (month) (day) (year)
Cemetery or crematory: Brooke Grove
Location: Laytonsville, Md.

18. Funeral director: Robert L. Snowden
Address: 246 N. Wash. St. Rockville, Md

19. 2/6 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb - 3, 1947, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam case, 19..., to ..., 19...
and that I last saw him alive on ..., 19...

Immediate cause of death	DURATION
Shock,	2 hrs
Due to: Retro-peritoneal hemorrhage	
Due to: accidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 2-2-47
Where did injury occur? Germantown (City or town) Montg. (County) Md. (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto. accident Injured at work? No

23. SIGNATURE: Frank J. Broccard M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 2-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01803

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55)

CERTIFICATE OF DEATH

Reg. Dist. No. 7160

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville (If outside city or town limits, write RURAL and give nearest town)

Street No. 215 Monroe (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary O. Edmonston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Albert R. Edmonston 6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 18, 1887

8. AGE: Years	Months	Days	If less than one day
59	5	19	hrs. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles P. Orton

13. Birthplace (deceased) New York.

MOTHER 14. Maiden name Cuyler Fant

15. Birthplace Virginia

16. Informant husband, Albert R. Edmonston

Address 215 Monroe St., Rockville, Md.

17. cremation (Burial, cremation, or removal. Which?) Date thereof 2/8/47 (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Suitland, Md.

18. Funeral director W. Reuben Trumbauer

Address 7557 Wisconsin Ave., Bethesda 14 Md

19. 2/7 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947 at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21 1947, to Feb. 6 1947 and that I last saw h.e.r. alive on Feb 6 1947

Immediate cause of death	DURATION
(1) Hypertensive heart disease with acute cardiac dilatation and failure	10 years 4 days
Due to (2) Squamous cell carcinoma of right lower leg.	2 yrs.
Due to (3) Elephantiasis, severe, both lower & upper legs.	13 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Amputation, right leg, low thigh for carcinoma Date of op. Jan. 31, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William S. McLure M.D. M. D. or other

Address 5610 Moorland Lane, Bethesda Date signed Feb 6, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55.2) X

01804

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 78 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 78 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chevy Chase Club
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FIELD, Mildred Fearn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Richard Stockton Field
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): 8 December 1890

8. AGE: Years	Months	Days	If less than one day
56	1	23	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Richard Lee Fearn
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Eleanora Egerton
15. Birthplace: Maryland

16. Informant: Richard Stockton Field
Address: Chevy Chase Club, Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-3-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: WM. Reuben Pumphrey P. D. P.
Address: 7557 Wisconsin Avenue, Bethesda, Md.

19. Feb 2 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 February 1947 at 2:03 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 1946 to 1 Feb. 1947 and that I last saw her alive on 1 Feb. 1947

	DURATION
Immediate cause of death: (Reticulum cell sarcoma) Lymphoma of neck Cervical lymph glands & metastases to retroperitoneal and periaortic nodes, hilus of left kidney and lungs.	3 months
Due to:	
Due to:	
Other conditions: Atelectasis - right lung and left lower lobe of lung Ascites Hydrothorax Phlebothrombosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Lymphoma of neck Date of op. 12/16/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. C. OWENS, LtCdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS-A15 9-45-15M

2/20/47

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6) X

CERTIFICATE OF DEATH

01805

Reg. Diat. No. 2230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos. 17 days

Hospital, institution, or street address where death occurred:
Wash. Sanitarium & Hospital

How long in hospital or institution? 4 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Wash. D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Douglas St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edith Fuge

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe.	White	widowed

6.(b) Name of husband or wife: Evans Jahn Fuge

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 29, 1877

8. AGE: Years	Months	Days	If less than one day
69	10	22	hrs. min.

9. Birthplace: Plymouth, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: England

MOTHER
14. Maiden name: Unknown
15. Birthplace: England

16. Informant: Mr. Raymond E. Fuge (Son)

Address: 200 Douglas St. NE. Wash. D.C. 2/8/47

17. Removal. Date thereof (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory: Washington D.C.

Location: Martin W. Tyson Co.

18. Funeral director: 1300 "N" St. N.W. Washington, D.C.

Address: Feb. 8 1947 J. Walter Reed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8th 1947, at 605 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 21 1946, to Jan. 8 1947

and that I last saw h.e.r. alive on Jan. 7 1947

Immediate cause of death	DURATION
INANITION - STARVATION	4 days
Due to: CARCINOMA OF THE UTERUS.	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lionel Roth, M.D.
M. D. or other

Address: Washington San. & Hosp. Date signed: 2/8/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01806

Reg. Dist. No. 1223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL und give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Silver Spring

(If outside city or town limits, write RURAL und give nearest town)

Street No. 9405 Louis Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Adelaide Seevers Fuller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Caucasian	Widowed

6.(b) Name of husband or wife: Ellis J.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 26 1883

8. AGE: Years	Months	Days	If less than one day
63	10	26	hrs. min.

9. Birthplace: Winchester Virginia. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: James Hamilton

FATHER 13. Birthplace: Winchester Va.

MOTHER 14. Maiden name: Rebecca Susan Stricker

MOTHER 15. Birthplace: Winchester Va.

16. Informant: Records - Washington San. & Hosp.

Address: Takoma Park Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 22 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Mt Hebron

Location: Winchester - Frederick Co - Va.

18. Funeral director: Dawes & Pumphrey

Address: Silver Spring - Md.

19. FEB 25 1947 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21 19 47, at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/6/ 19 47 to 2/21/ 19 47

and that I last saw h[illegible] alive on 2/20/ 19 47

Immediate cause of death: Scirrhous Carcinoma of the Stomach with

Due to: Generalized metastasis to the lumbar retroperitoneal

Due to: glands, ovaries, pancreas and adjacent tissues

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: 12 mos

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John F. Brownlee M. D. or other

Address: Washington Sanitarium Takoma Park, Md. Date signed: 2/25/47

1-35

01807

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

CERTIFICATE OF DEATH

MV ★ Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 min.

Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hosp.

How long in hospital or institution? 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Forest Glen
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1518 Seminary Rd
(If rural, give LOCATION)

2.(a) If veteran, name war No ✓

3. (a) FULL NAME Robert Joseph Gray

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov - 1 - 1941

8. AGE: Years	Months	Days	If less than one day
5	3	23.	..... hrs. ..... min.

9. Birthplace WASHINGTON D.C.
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business —

FATHER
12. Name C. WILLIAM GRAY
13. Birthplace CHARLOTTE N.C.

MOTHER
14. Maiden name MARIE STANNER.
15. Birthplace JOHNSON · MINN.

16. Informant C. WILLIAM GRAY
Address 1518 SEMINARY RD. SILVER SPRING MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2-26-1947 (month) (day) (year)

Cemetery ~~or crematory~~ ROCK CREEK

Location WASHINGTON · D.C.

18. Funeral director Warner E. Pumphrey.

Address SILVER SPRING MD.

19. Feb 25 1947 (Date rec'd by registrar) William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1947, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19.. to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Compound Comminuted Fracture of skull	40 min.
Due to (accidental)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-24-47

Where did injury occur? Forest Glen (City or town) Mont. (County) Md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury struck by auto Injured at work? No

23. SIGNATURE Frank J. Borchart M. D.
DR Fed. Exam
M. D. or other

Address Gaithersburg Md Date signed 2-24-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

★ 01808

Reg. Diat. No. 2112

1. PLACE OF DEATH:

County Montgomery

City or town Friendship MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Friendship MD Monrovia R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Willie S. Gray

3.(b) Social Security Number 214-16-7709

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 16. 1897

8. AGE:

Years	Months	Days	If less than one day
49	3	21	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business John Hopkins Silverspring

FATHER 12. Name George M.C. Gray

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Taylor

MOTHER 15. Birthplace Maryland

18. Informant Lillie Lyles

Address Monrovia MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 8 th 1947 (month) (day) (year)

Cemetery or crematory Friendship MD

Location Montgomery CO.

18. Funeral director Roy W. Barber

Address Laytonsville MD

19. Feb 8 1947 (Date rec'd by registrar) Della W Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1947, at 2: P: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1946, to February 5 1947

and that I last saw h.i.m. alive on February 3 1947

Immediate cause of death Coronary occlusion — DURATION 10 minutes

Due to Arteriosclerotic Cardiovascular disease. — 5 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James D. Kerr M.D. M. D. or other

Address Damascus, Md. Date signed 2/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-C)

CERTIFICATE OF DEATH

01809

Reg. Diat. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours, 45 min.

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 hours, 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 6th St., N.E. Apt. 304

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Girl Haley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1947

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 45 min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: John F. Haley

FATHER — 13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Hilda Irene LaDuke

MOTHER — 15. Birthplace: N.Y.

16. Informant: fa: Mr. John F. Haley

Address: 116th 6th St., N.E., Wash., D.C., Apt. 304

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2-8-47 (month) (day) (year)

Cemetery or crematory: Geo. Wash. Memorial

Location: Hyattsville, Md.

18. Funeral director: W. W. CHAMBERS W. W. MacLean

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 2-8 (Date rec'd by registrar) 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 Feb. 1947 at 3:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Feb. 1947 to 7 Feb. 1947 and that I last saw her alive on 7 Feb. 1947

Immediate cause of death	DURATION
Anencephalic monster.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Peterson PAUL PETERSON, Capt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-8-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2/15/47

2-25

2 - 2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

01810

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2/14/47

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: Gallitzin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 311 St. Thomas St.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: HALL, Guy Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 21, 1914

8. AGE: Years	Months	Days	If less than one day
33	0	13	hrs. min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business

FATHER
12. Name: Gertrude Convery Dec.
13. Birthplace: Penn.

MOTHER
14. Maiden name: Alex Hall Dec.
15. Birthplace: Penn.

16. Informant: Aunt: Mrs. P. J. Hall
Address: 311 St. Thomas St., Gallitzin, Pa.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-6-47 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery
Location: Cresson, Penn.

18. Funeral director: W. W. CHAMBERS
Address: 1400 ChapinSt. N.W., Wash., D.C.

19. 2-5 (Date rec'd by registrar) 19 57 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 February 19 47, at 8: P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Jan 19 47, to 4 Feb. 19 47 and that I last saw h im alive on 4 Feb. 19 47

Immediate cause of death	DURATION
Myocardial Infarction	5 days
Due to Coronary thrombosis	5 days
Due to Col. art. sclr	
Other conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson, Lt. Comdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-5-47

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

CERTIFICATE OF DEATH

★ 01811

Reg. Dist. No. 2/2

1. PLACE OF DEATH:
County Montgomery
City or town Poolesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Monty
City or town Poolesville, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julius Hall

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Margaret
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Nov 26-1870

8. AGE: Years 76 | Months 2 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace Poolesville, Monty Co. Md (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name John B. Hall
13. Birthplace Md

MOTHER
14. Maiden name Sarah Strickman
15. Birthplace Md.

16. Informant Mrs Julius Hall
Address Poolesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb-18-47 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville, Md

18. Funeral director William B Hilton
Address Barnesville, Md

19. Feb 17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1947 at 2 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Feb 16 1947
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: INFARCTION OF MYOCARDIUM	1 HR
Due to: Coronary Occlusion	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Albert K. Johns, MD M. D. or other
Address Poolesville, Md Date signed 2/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01812 Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, institution, or street address where death occurred:
6702 - 46th Street
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6702 - 46th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: CHARLES ABRAM HARGETT

3.(b) Social Security Number: 577-34-6936

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Clara A. Hargett
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): April 12, 1867

8. AGE: Years	Months	Days	If less than one day
79	9	22	...hrs. ...min.

9. Birthplace: Frederick, Frederick Co., Md.
(Town, county, and state)
10. Usual occupation: Nurseyman
11. Industry or business:

FATHER
12. Name: Hiram Abram Hargett
13. Birthplace: Frederick, Maryland

MOTHER
14. Maiden name: Sophie Hildebrand
15. Birthplace: Frederick, Maryland

16. Informant: Mrs. Charles Abram Hargett
Address: 6702 - 46th St., Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery.
Location: Frederick, Maryland

18. Funeral director: Mr Reuben Pumphrey
Address: 7557 Wis. Ave, Bethesda, 14, Md.

19. 2/6 (Date rec'd by registrar) 1947 Wm E Jabes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam Case 19... to ...19...
and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death	
Coronary occlusion	Instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Brochart M. D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 1-5-47

01813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 247

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 hrs
Hospital, Institution, or street address where death occurred: Montgomery County Gen. Hospital
How long in hospital or institution? 18 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr Royal Vernon Harp Sr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1892

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	3	6		

9. Birthplace: Taylor Maryland (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business
FATHER 12. Name: Jacob Harp
13. Birthplace: Md
MOTHER 14. Maiden name: Blanche Johnson
15. Birthplace: Md
16. Informant: Royal V Harp Jr.
Address: Clayton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-19-47 (month) (day) (year)
Cemetery or crematory: Mt View
Location: Alpha Md
18. Funeral director: F.C. Higinbotham
Address: Ellicott City Md
19. Feb. 18, 1947 (Date rec'd by registrar) John D. Loughran Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17 1947 at 5:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1947 to Feb 17 1947 and that I last saw him alive on Feb 16 1947

Immediate cause of death	DURATION
Diabetic acidosis & coma	18 hrs
Due to: Diabetis mellitis	10 yrs
Due to:	
Other conditions: Cerebral hemorrhage	1 week

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles S. Whitaker M.D. (M. D. or other)
Address: Clarksville, Md. Date signed: 2-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

01814

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 hrs 20 min
Hospital, institution, or street address where death occurred:
Montgomery County Gen. Hospital
How long in hospital or institution? 29 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Clarksville Rt
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby girl Howard

3.(b) Social Security Number

4. Sex: Fem
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): February 12, 1947
8. AGE: Years | Months | Days | If less than one day: 6 hrs. 20 min.
9. Birthplace: Olney Maryland (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Coy Allen Howard
13. Birthplace: Tennessee
MOTHER 14. Maiden name: Bonnie Mae Davis
15. Birthplace: Tennessee
16. Informant: Hosp. rec.
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-47 (month) (day) (year)
Cemetery or crematory: Home Cem.
Location: Ellicott City, Md.
18. Funeral director: Coy A. Howard (father)
Address: Ellicott City, Md.
19. 2-13-1947 (Date rec'd by registrar) Gertrude B. Lawler, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1947, at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1947 to Feb 13 1947
and that I last saw him alive on Feb 13 1947
Immediate cause of death: Prematurity (4½ months gross)
DURATION: 29 hrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D. (M. D. or other)
Address Clarksville, Md. Date signed 2-14-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

★ 01815

CERTIFICATE OF DEATH

Reg. Dist. No. 7160

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28½ hours

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 28½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Ohio County Hamilton

City or town Cincinnati
(If outside city or town limits, write RURAL and give nearest town)

Street No. Kemperlane Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war ——

3.(a) FULL NAME CLYDE L. HIRLEMAN

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Eva B. Hirleman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	17	..... hrs. ..... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Technician on Staff of Bureau

11. Industry or business of Internal Revenue

FATHER
12. Name George W. Hirleman
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Anna Garrison
15. Birthplace Pennsylvania

16. Informant Samuel S. Harvey, nephew
Address 506 Miss. Ave., Silver Spring, Md.

17. Shipment and burial Date thereof Feb. 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Benton Cemetery

Location Benton, Columbia County, Pa.

18. Funeral director Waxnex E. Pumphrey

Address Silver Spring, Maryland

19. 2/15 1947 Mrs E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 14th 1947 at 5:25 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Feb 1947 to 14 Th Fr 1947 and that I last saw h.. alive on 14 Feb 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	about 1 mo.
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William D. Aud, M.D.
M. D. or other

Address 9006 Colesville Rd., S.S. Date signed 2-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-36

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

★ 01816

Reg. Dist. No. 2231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

217 Holly St

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Hadley St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James D. Holland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... yeere

7. Birth date of deceased (mo., day, yr.) Jan 1 1947

8. AGE: Years	Months	Days	If less than one day
—	1	17	..... hrs. ..... min.

9. Birthplace: Prince Georges Co Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: James B. Holland

FATHER — 13. Birthplace: Waldorf md

MOTHER — 14. Maiden name: Carrie Mullins

MOTHER — 15. Birthplace: W. Va

16. Informant: Daisy La Coffreen

Address: 3815 37th St Mt Rainy md

17. (Burial, cremation, or removal, Which?) Removal Date thereof 2-18-47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: 3201 Bladensburg Rd. Bladensburg, Md

18. Funeral director: Wm. J. Malley

Address: 3200-R.I. Ave. Mt. Rainier, Md.

19. 2-18 1947 (Date rec'd by registrar) H. Weidler Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18 19 47, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1946 19 ..... to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Asphyxia by suffocation	Some Hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external ceuses, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Borchart M.D. M. D. or other

Address: Takoma Park md Date signed 2-18-47

1-25

2-2230—1-10

MARYLAND STATE DEPARTMENT OF HEALTH

01817

2411 N. Charles St., Baltimore (95-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Apt. #3, 2424 North Sixteenth St.
(If rural, give LOCATION)
2.(a) If veteran, name war: W W I ✓

3.(a) FULL NAME: HORTON, Rodney Augustus Chapman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Addie Horton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 28 May 1890

8. AGE: Years	Months	Days	If less than one day
56	8	29	..... hrs. ..... min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Veterans Administration
11. Industry or business: Washington, D. C.

FATHER
12. Name: David D. Horton dec.
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Chapman dec.
15. Birthplace: unknown

16. Informant: wife: Mrs. Addie Horton
Address: Apt. #3, 2424 North Sixteenth St., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3-3-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS
Address: Georgetown, D.C.

19. 2-27 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 February 19 47, at 12:45 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 26 February 1947, to 27 February 1947 and that I last saw him alive on 27 February 1947

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: Chronic cor pulmonale	
Due to: Emphysema.	
Other conditions: Bronchopneumonia, Myocardial infarction, old	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: Chronic Cor Pulmonale

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. W. Thompson C. W. THOMPSON, Lt. Cdr. (MC) USNR (M. D. or other)
Address: USNH Bethesda, Md. Date signed: 2-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

3/6/47

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (165)

CERTIFICATE OF DEATH

01818

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? few minutes

Hospital, Institution, or street address where death occurred: Chevy Chase Country Club

How long in hospital or Institution? few minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D.C. County: District of C.

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 4514 Conn Ave (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Baby boy Hottel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): Feb 6 1947

8. AGE: Years: — Months: — Days: — If less than one day: — hrs. 15? min.

9. Birthplace: Chevy Chase (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Ruth Hottel

MOTHER — 15. Birthplace: North Fork, Va

16. Informant: Monty Co Police records

Address: Bethesda Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 22, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Zion Church Cemetery

Location: Bethesda, Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Maryland

19. 2/21/1947 (Date rec'd by registrar) Wm E Jarboe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6 1947 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec med. Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death: asphyxia due to strangulation (homicide) — Duration: Few min dead

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of 2-6-47

Where did injury occur? Chevy Chase (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart Dep. Med. Exam M. D. or other

Address: Gaithersburg Md Date signed: 2-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01819

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 18 days
Hospital, Institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 1 month, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1619 A Street, NE, Washington, D. C.
(If rural, give LOCATION)
2.(a) If veteran, name war: W W I

3.(a) FULL NAME: HULL, Lewis "N"

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Edna Hull
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 21 February 1888

8. AGE: Years	Months	Days	If less than one day
59	0	7	hrs. min.

9. Birthplace: Missouri
(Town, county, and state)
10. Usual occupation: Printer-Proof Reader
11. Industry or business: Government Service

FATHER
12. Name: George Hull
13. Birthplace: Missouri

MOTHER
14. Maiden name: Alice Von Schlipsey
15. Birthplace: Missouri

16. Informant: Mrs. Edna Hull
Address: 1619 A St, NE, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-4-47 (month) (day) (year)
Cemetery or crematory: Woodmere Cemetery
Location: Huntington, West Virginia

18. Funeral director: W. W. Chambers
Address: 517 11th Street, SE, Washington, D.C.

19. Feb 28 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 28 1947 at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1947, to 9:00 2/28 1947 and that I last saw h.i.m. alive on 2/28 1947

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Coronary thrombosis	1 wk.
Due to:	
Other conditions: Hypertension, Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Coronary thrombosis (gross)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C.W. THOMPSON, LCDR MC USNR
M. D. or other
Address: USNH Bethesda Md Date signed: 2-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

316/47

2 - 2160 — 2 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01820

CERTIFICATE OF DEATH

Reg. Diat. No. 2130

1. PLACE OF DEATH:
County Montgomery
City or town R.F.D #3 Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sept 27, 1946
Hospital, institution, or street address where death occurred:
Waverley Sanitarium
How long in hospital or institution? Sept 27, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1539 NORTH FALKLAND LANE
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Maria Rust Iddings

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Ernest L. Iddings 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 7 - 1861

8. AGE: Years	Months	Days	If less than one day
85	3	6	..... hrs. ..... min.

9. Birthplace Leesburg Va
(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

FATHER 12. Name George Thomas Rust

13. Birthplace Landown Co. Va.

MOTHER 14. Maiden name Rebecca Coleman Talbott

15. Birthplace Maryland

16. Informant Mrs. Elsie Cook - Daughter

Address 1539 N. Falkland, Silver Spring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15, 1947 (month) (day) (year)

Cemetery ~~or crematory~~ Woodside Cemetery

Location Brinkley, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Feb 22 1947 Betty Jane Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 3 Feb. 1947, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Dec. 1947, to 13 Feb. 1947 and that I last saw h~~e~~r alive on 13 Feb. 1947

Immediate cause of death	DURATION
Cardiac - Failure Myocardial degeneration	3 days.
Due to Cardiac Decompensation -	6 Mo.
Due to arterial Hypertension -	20 yr.
Other conditions arterial sclerosis.	30 yr.

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op. .....

Autopsy results None done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John B. Ball M.D.
M. D. or other

Address 7936 Bonnyton Rd. Bethesda Md. Date signed 13 Feb 47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01821

Reg. Dist. No. 2160

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MacArthur Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Carderock, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bethesda, Maryland R.F.D. # 3
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Robert F. Jenkins

3.(b) Social Security Number: 577-22-3048

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Delia Roberts Jenkins
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): October 2, 1888

8. AGE: Years	Months	Days	If less than one day
59	4	15	....hrs. ....min.

9. Birthplace: Montgomery County Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: William Jenkins
13. Birthplace: Louden, Va.

MOTHER
14. Maiden name: Laura Grimes
15. Birthplace: Louden, Va.

16. Informant: Mrs. Delia R. Jenkins
Address: Carderock, Md. R.F.D. Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/20/47 (month) (day) (year)
Cemetery or crematory: Potomac Church Cemetery
Location: Potomac, Maryland

18. Funeral director: Wm Reuben Humphreys
Address: Bethesda, Maryland

19. 2/18/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17, 1947, at 3 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiner to Case 19
and that I last saw h... alive on ... 19

Immediate cause of death	DURATION
Coronary occlusion	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. G. Crawford M. D.
Sub. Med. Examiner Montgomery County or other
Address: Rockville, Md. Date signed: 2/19/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193)

CERTIFICATE OF DEATH

01822

Reg. Dist. No. 7160

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, Institution, or street address where death occurred:
Suburban Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. Maryland County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1417 Columbia St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Earl H. Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	seperated

6.(b) Name of husband or wife: seperated

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan Sept. 20, 1905

8. AGE: Years	Months	Days	If less than one day
42	1	6	hrs. min.

9. Birthplace: louisa Virginia
(Town, county, and state)

10. Usual occupation: Helper - Park Transfer Co.

11. Industry or business: " " "

FATHER
12. Name: Philip Johnson
13. Birthplace: louisa, Va.

MOTHER
14. Maiden name: Blanche Carter
15. Birthplace: louisa, Va.

16. Informant: Sylvester Johnson bro
Address: 3022-14 st. N.E Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/2/47 (month) (day) (year)

Cemetery or crematory:

Location: Louisa - Va

18. Funeral director: Leon E. Murray

Address: 1337-10 th N.W Wash DC

19. 2/26 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 26 19 47, at 2:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept Med Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
electrocution accidental	killed instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: accident Date of 2-26-47

Where did injury occur? Rockville (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: Contacted high tension wire Injured at work? yes

23. SIGNATURE: Frank J. Brockhurst M.D. M. D. or other

Address: Gaithersburg md Date signed 2-26-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Z-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) X

CERTIFICATE OF DEATH

*01823

Reg. Dist. No. 2130

1. PLACE OF DEATH:
County Montgomery
City or town Rockville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Todd Ville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elora Johnson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

B.(b) Name of husband or wife Asbury Johnson
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) October 1894

8. AGE: Years 52 | Months 4 | Days | If less than one day ... hrs. ... min.

9. Birthplace Front Royal Va.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Asbury Johnson
Address Falls Rd. Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28, 1947 (month) (day) (year)
Cemetery or crematory Lincoln Park
Location Rockville, Md.

18. Funeral director Robert L. Snowden
Address Rockville Md.

19. 2-28 1947 (Date rec'd by registrar) Bettie Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1947 at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1946 to Feb 25 1947 and that I last saw h.e.r. alive on 10/23 1946

Immediate cause of death	DURATION
Carcinoma of Breast	
Due to Metastasis to lungs & joint	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C E Hawks M. D. or other
Address Rockville Md Date signed 2/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-55

01824

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

CERTIFICATE OF DEATH

Reg. Dist. No. 2161

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos. 15 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 2 mos. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5204 St. Barnabas Rd. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: KAISER, JOSEPH ANTHONY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Edna Kaiser
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 21 December 1875

8. AGE: Years	Months	Days	If less than one day
71	1	27	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Edna Kaiser
Address: 5204 St. Barnabas Rd.SE, Wash.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-20-47 (month) (day) (year)
Cemetery or crematory: Arlington, National
Location: Arlington, Virginia

18. Funeral director: W. W. Chambers RW3.
Address: 1400 Chapin Street, NW, Wash., D.C.

19. Feb. 18 1947 (Date rec'd by registrar) Mary Elizabeth Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 February 1947, at 3:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/17 1947, to 2/18 1947
and that I last saw h[illegible] alive on 2/17 1947

Immediate cause of death	DURATION
Cardiac Arrest	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. W. Mulder
D. W. MULDER LTJG MC USNR M. D. or other
Address: USNH, Bethesda, Md. Date signed: 2/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/4/47

2-25

2-2160 — 2-10

01825

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred: none
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Germantown (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME ELIAS DORSEY KING
3.(b) Social Security Number None

4. Sex Male | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Hattie G.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) October 23, 1861

8. AGE: Years 85 | Months 4 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Montgomery Co. Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name John M. King
13. Birthplace Maryland
MOTHER 14. Maiden name Amy Brewer
15. Birthplace Maryland
16. Informant Mrs. Martin W. Porrey (Daughter)
Address 4704 Merivale Rd. Ch.Ch., Md.
17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Frederick, Md.
18. Funeral director Wm Reuben Pumphrey
Address 7557 Wisconsin Ave., Bethesda, Md.
19. 2/27 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1947, at 8 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Feb 26 1947
and that I last saw him alive on Feb. 25 - 1947

	DURATION
Immediate cause of death: Congestive Heart Failure	10 days
Due to: Hypertensive Cardio-vascular disease	1 1/2 + yrs
Due to	
Other conditions: Arteriosclerosis (Generalized) (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Leo Brown Norris M.D. (M. D. or other)
Address 2204 R St. NW Wash DC Date signed 2/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-0)

CERTIFICATE OF DEATH

01826

Reg. Dist. No. 216-0

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hrs - 15 min.

Hospital, Institution, or street address where death occurred:
Suburban Hosp. — Bethesda, Md.,

How long in hospital or institution? 10 hrs — 15 min.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Monty

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Lincoln Park
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm. King

3.(b) Social Security Number

4. Sex: M

5. Color or race: colored

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1886

8. AGE: Years 60 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace N. Carolina
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 13, 1947 (month) (day) (year)

Cemetery or crematory County Home

Location Rockville, Md.

18. Funeral director R. L. Snowden

Address 246 N. Wash St. Rockville Md.

19. 2/17 (Date rec'd by registrar) 1947 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-'47 1947, at 7 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 Med. Exam 1947, to 1947

and that I last saw h alive on 1947

Immediate cause of death ..... DURATION

Methyl alcohol poisoning 1 x hr.

Due to

Accidental. Found in jug, and drank con-

Due to tents. C.W. & R.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bronhart M.D. Dep Med Examiner M. D. or other

Address Rockville Md Date signed 2-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01923

MV Reg. Dist. No. 2450

1. PLACE OF DEATH:

County: Prince Georges Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Washington Sanitorium and Hospital

How long in hospital or institution? Dead on Arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3112 McComas Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME Ralph Ly Z Kirk

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 23, 1926

8. AGE: Years: 21 | Months: 0 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Danville Va.

(Town, county, and state)

10. Usual occupation: Jockey

11. Industry or business: Race Horses

FATHER 12. Name: Thomas W Kirk

FATHER 13. Birthplace: Salisbury N. C.

MOTHER 14. Maiden name: Bertha Alice Allred

MOTHER 15. Birthplace: Randleman N. C.

16. Informant: Thomas W Kirk

Address: 3112 McComas Ave.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: FEB 19 1947 (month) (day) (year)

Cemetery or crematory: Colesville Methodist Church

Location: Colesville - Mont Co. - Md

18. Funeral director: Ward E Pumphrey

Address: Silver Spring Md

19. Feb 20 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Sept~~ Feb 16 1947, at 1 05 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Fracture of skull Crushed pelvis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 2-16-47

Where did injury occur? College Park P.G. Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (Which?) Home Auto Race Track

Means of injury: Danger in earth Injured at work? Yes

Keeping medical Examiner

23. SIGNATURE: James H Ley M. D. or other

Address: Kensington Md Date signed: 2-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

01827

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Rural - Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: 10230 New Hampshire ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10230 New Hampshire ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lewis Hoyt Lamb

3.(b) Social Security Number 579-18-9746

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lottie Marion Lamb
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 13 December 1880

8. AGE: Years	Months	Days	If less than one day
66	1	20	hrs. min.

9. Birthplace: Washington D C
(Town, county, and state)
10. Usual occupation: Pharmacist
11. Industry or business

FATHER
12. Name: William L. Lamb
13. Birthplace: Vermont

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. L. M. Lamb
Address: Silver Spring, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1947 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington D C

18. Funeral director: The S. H. Hines Co
Address: 2901 14th St N.W.

19. Feb 2 19 47 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 Feb 19 47, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 40, to 2 Feb 19 47
and that I last saw h alive on 2 Feb 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 hours
Due to: Hypertension	about 10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William D. Aud M.D.
M. D. or other
Address: Silver Spring Md Date signed 2 Feb 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-H)

CERTIFICATE OF DEATH

★ 01828

Reg. Diat. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:
7024 Wis. Ave. Bethesda, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7024 Wis. Ave. Bethesda, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3.(a) FULL NAME Clyde W. Martin

3.(b) Social Security Number 579-07-7570

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Hermanson Martin

6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) August 31, 1915

8. AGE: Years	Months	Days	If less than one day
31	5	15	..... hrs. ..... min.

9. Birthplace Carthage, N. C.
(Town, county, and state)

10. Usual occupation Chef, Tasty Diner

11. Industry or business

FATHER
12. Name Lee O. Matin
13. Birthplace Charlotte, N. C.

MOTHER
14. Maiden name Anna M. Simpson
15. Birthplace Unknown

16. Informant Mrs. Helen H. Martin

Address 7024 Wis. Ave. Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/47 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director Wm Reuben Dunphrey

Address Bethesda, Maryland

19. 2/15 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1947 at 1:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med Exam case 19.. to 19..

and that I last saw h... alive on 19..

Immediate cause of death	DURATION
Asphyxia by obstruction of	
Due to Suicide	2 min
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Suicide Date of 2-15-47

Where did injury occur? Bethesda (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchat M.D. Dep. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 2-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 716 — 01829

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Mont

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:
512 Park Lane

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 512 Park Lane
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: NORMA McDERMOTT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles K. McDermott

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 13, 1877

8. AGE: Years	Months	Days	If less than one day
69	4	9	..... hrs. ..... min.

9. Birthplace: Charleston, West Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Henry D. MacFarland

FATHER — 13. Birthplace: Charleston, West Virginia

MOTHER — 14. Maiden name: Ellen Dashiell

MOTHER — 15. Birthplace: Princess Ann, Maryland

16. Informant: Nell D. McDermott

Address: 512 Park Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/25/47 (month) (day) (year)

Cemetery or crematory: Mont. Memorial Park

Location:

18. Funeral director: S. H. Hines Co.

Address: 2901-14th St. N.W. Wash. DC.

19. 2/22 /47 (Date rec'd by registrar) — M E Jones — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 19 47 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to February 22 19 47 and that I last saw her alive on 2/21 19 47

Immediate cause of death	DURATION
Respiratory Failure	
Due to Carcinoma of the Bladder with	
Due to widespread metastasis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank Jaggers M.D.
M. D. or other

Address: 806 Georgetown Rd Bethesda, Md. Date signed 2/22/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

01830

2411 N. Charles St., Baltimore (137-E)

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 53 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st WW

3. (a) FULL NAME
MEAD, Ernest Roy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 October 1880

8. AGE: Years	Months	Days	If less than one day
66	4	3	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)
10. Usual occupation: unknown
11. Industry or business

FATHER
12. Name: Simmon Mead
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Elenora Maxson
15. Birthplace: Pennsylvania

16. Informant: Mr. Samuel Mead
Address: Centerville, Pennsylvania

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-26-47 (month) (day) (year)
Cemetery or crematory: Arlington Nat. Cemetery
Location: Arlington Va.

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St. N.W. WASH. D.C.

19. 2-22 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 February 19 47 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 19 46 to 21 Feb. 19 47 and that I last saw him alive on 21 February 19 47

Immediate cause of death	DURATION
Pulmonary embolism	3 days
Due to Prostatectomy ? for benign hypertrophy of prostate. Cancer.	2 wks. P.M.
Due to	
Other conditions Followed by a fatal pulmonary embolism.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson
C. W. THOMPSON LCDR MC USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ink correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15 9-45-15M

2/24/47

2-25

2-2160 — 2-10

01831

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 7140

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 502 - East Wayne Ave -

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/4/66

8. AGE: Years 81 | Months 1 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace: Elmer, Md.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: William Moore
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah Frances Keith
15. Birthplace: Md

16. Informant: Mrs. Elmer Moore
Address: 502 East Wayne Ave - Sil

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28-1947 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Pottsville Pa

18. Funeral director: Thomas Walters

Address: 254 - Carroll St - Takoma Park

19. Feb 27 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb - 26 19 47, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1945, to Feb. 26 1947

and that I last saw her alive on Dec. 5, 1946

Immediate cause of death	DURATION
"Coronary Thrombosis"	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Charles J. Carroll M.D.
M. D. or other

Address: 6801 - 6th St. N.W. Wash. D.C. Date signed 2/26/47

Certificate Approved
by Dr. B Roschart.
Medical examiner.
Feb. 26-1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2) ×

CERTIFICATE OF DEATH

01832

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Mont.

City or town: Westgate

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5408 Earlston Drive

(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd W.W.

3.(a) FULL NAME: MILES, Herbert Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Ida E. Miles

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 1, 1908

8. AGE: Years	Months	Days	If less than one day
39	0	11	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Agriculture Dept.

11. Industry or business:

FATHER — 12. Name: Herbert R. Miles

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary E. Greaser

15. Birthplace: Md.

16. Informant: wife: Mrs. Ida E. Miles

Address: 5408 Earlston Drive, Westgate, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2-15-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Reuben PUMPHREY H.J.W.

Address: 7557 Wisconsin Avenue, Bethesda, Md.

19. 2-12 (Date rec'd by registrar) 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 February 1947 at 10:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Feb. 1947 to 12 Feb. 1947

and that I last saw him alive on 12 Feb. 1947

Immediate cause of death	DURATION
Bronchiogenic carcinoma - left upper lobe - with massive atelectasis + extensive	
Due to: metastases	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Metastatic adenocarcinoma to parietal region Date of op.

Autopsy results: Bronchiogenic carcinoma - left

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E.N. Weaver
E.N. WEAVER, Lt.(jg)(MC) USNR

Address: USNH Bethesda, Md. M. D. or other Date signed: 2-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/20/47

2-25-

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01833

Reg. Dist. No. 2-17

1. PLACE OF DEATH:

County: Montgomery

City or town: Fairland (Fairland)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: (Fairland)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Logan Miles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: Ephraim Miles

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4/6/1878

8. AGE: Years	Months	Days	If less than one day
68	2	2	....hrs. ....min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Martin Logan
13. Birthplace: Md

MOTHER
14. Maiden name: Mary Bennett
15. Birthplace: Md.

16. Informant: Mrs Beulah Ely
Address: Fairland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 5 1947 (mouth) (day) (year)

Cemetery or crematory: Burtonsville Union

Location: Burtonsville Maryland

18. Funeral director: Warren E. Pumphrey

Address: Silver Spring Md.

19. 2-3 1947 (Date rec'd by registrar) Geo. Truett B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/27 1947, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1 1946 to 9/27 1947 and that I last saw her alive on 9/23 1947

Immediate cause of death	DURATION
Coronary Thrombosis	30 min
Due to: Sen Arteriosclerosis	2
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring Md. Date signed: 9/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

260 Maple

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

01834

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Mont.
City or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 mos
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Mont.
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7820 Custer Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME (ANNIE) ANNA GAWLER MONROE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife HUGH MONROE
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1861

8. AGE: Years 85 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Wash DC
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Joseph Fawler
13. Birthplace Eng

MOTHER 14. Maiden name Louise Renner
15. Birthplace Md.

16. Informant Clara G. Hurley
Address 7820 Custer Rd Bethesda Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-4-47 (month) (day) (year)

Cemetery or crematory Oak Hill
Location Wash. DC.

18. Funeral director Joseph Fawler Sons
Address 1756 - Pa. Ave NW.

19. Feb. 4 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 47 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 45 to February 19 47 and that I last saw her alive on February 3 19 47

Immediate cause of death	DURATION
Respiratory Failure	
Due to Cerebral Thrombosis	
Due to	
Due to	
Other conditions Diabetes Mellitus	
Old fractured right hip	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Jaggers Jr. M.D.
M.D. or other
Address 8016 Georgetown Rd Date signed 2/4/47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2/4/47 Coroner notified and approved 1 + jaggus

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

01835

CERTIFICATE OF DEATH

Reg. Dist. No. 2161

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 hours
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 14 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 133 North Irving St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MONTY, Helen Marie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Harold R. Monty
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 9 Nov. 1903

8. AGE: Years	Months	Days	If less than one day
43	2	9	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Dept. of Interior
11. Industry or business: Government
FATHER 12. Name: Clarence Talbert
13. Birthplace: Washington, D. C.
MOTHER 14. Maiden name: Cora Talbert
15. Birthplace: Washington, D. C.
16. Informant: husband; Mr. Harold R. Monty
Address: 133 North Irving St., Arlington, Va.
17. burial (Burial, cremation, or removal. Which?) Date thereof 2-21-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: S. H. HINES
Address: 2901 14th St., N.W., Wash., D.C.
19. 2-18 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 February 19 47, at 10:55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Feb. 19 47, to 18 Feb. 19 47
and that I last saw him alive on 18 Feb. 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Hypertensive cardio-vascular disease	
Due to:	
Other conditions: Congestive heart failure.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: No post performed.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. C. PARKER, Jr. Comdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2/24/47

2-25

2-2160 —. 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01836

CERTIFICATE OF DEATH

Reg. Dist. No. 2140

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
512 Ashford Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 512 Ashford Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MRS. ORREL MOODY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Fred. R. Moody
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1865

8. AGE: Years 82 | Months 1 | Days 14 | If less than one day: hrs. min.

9. Birthplace: Condersport, Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Jacob Peet
13. Birthplace: Condersport, Penna.

MOTHER
14. Maiden name: Eliza Ann Colcord
15. Birthplace: Bath, N. Y.

16. Informant: Mrs. Flora Leitzel
Address: 512 Ashford Rd., Silver Spring, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 2 (month) 23 (day) 47 (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Prince George County, Md.

18. Funeral director: L. H. Hines Co., Inc.
Address: Washington, D. C.

19. 2-24-20 (Date rec'd by registrar) 1947 Josephine M. Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1947 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26 1946, to February 20 1947
and that I last saw h... alive on Feb. 20 1947

Immediate cause of death	DURATION
Bronchitis & Obstruction	2 days
Due to: Carcinoma of Uterus	4 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. B. Wardrop M.D. M. D. or other
Address: 943 Bonifant St. Silver Spring, Md. Date signed: 2/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

01837

Reg. Diat. No. 2161

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rurel)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Green Acres
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: [illegible] MORSELL, Clara Hodges

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W-US	widowed

6.(b) Name of husband or wife: William Morsell.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19 1864

8. AGE: Years	Months	Days	If less than one day
82	8	22	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER — 12. Name: John Clark Hodges
13. Birthplace: Pennsylvania
MOTHER — 14. Maiden name: Ann Elizabeth Day
15. Birthplace: Conn.
16. Informant: bro: Mr. Edward R. Hodges
Address: Green Acres, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 2-12-47 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington, D. C.
18. Funeral director: S. H. Hines
Address: 2901 14th St., N.W., Wash., D.C.
19. 2-12 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 Feb. X 1947, at 4:30P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 February 1947, to 11 Feb. 1947 and that I last saw her alive on 11 Feb. 1947

Immediate cause of death	DURATION
Intarction of brain and myocandcum; congestive heart failure.	
Due to Generalized arterio-sclerosis	
Due to	
Other conditions Terminal broncho-pneumonia. (Include pregnancy within 3 months of death)	

Major findings of operation: Date of op.:
Autopsy results: See above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. C. Parker, Jr. R. C. PARKER, Jr., Comdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M 2/20/47

2-25

2-2160 —— 2-10

2162

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Institution~~ or street address where death occurred:
306 Birch Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Birch Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: ANNA KLING MUELLER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Gustave A.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 6th. 1860

8. AGE: Years	Months	Days	If less than one day
86	2	16	hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Peter Kling
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. William L. Gray (daughter)
Address: 306 Birch Ave. Takoma Park.

17. Removal & Burial Date thereof: 5-15-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Knollwood Cemetery

Location: Cleveland, Cuyahoga Co. Ohio.

18. Funeral director: Adams & Confahney.

Address: Silver Spring, Maryland.

19. May 14 1947 Josephine M. Scheffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb - 22 1947, at 3:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Aug - 10 1946, to Feb 22 1947
and that I last saw h. alive on Feb 21 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	4 days
Due to Cerebral accident	6 weeks
Due to Cerebral Arteriosclerosis	—
Other conditions Coronary Sclerosis	—

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: E. Stuart Bryddane Injured at work?

23. SIGNATURE: E. Stuart Bryddane M.D.
M. D. or other

Address: 3066 Connecticut Ave. Que St NW Date signed: 2/24/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01838

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
10,109 Hereford Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10,109 Hereford Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM MULLIGAN

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1946

8. AGE: Years	Months	Days	If less than one day
0	4	28	... hrs. ... min.

9. Birthplace: New York City, N. Y.
(Town, county, and state)
10. Usual occupation: ---
11. Industry or business: ---

FATHER
12. Name: Clement J. Mulligan
13. Birthplace: New York City, N. Y.

MOTHER
14. Maiden name: Ellen Nugent
15. Birthplace: New York City, N. Y.

16. Informant: Clement J. Mulligan
Address: 10,109 Hereford Pl., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-19-1947 (month) (day) (year)
Cemetery or ~~Crematory~~: St. John's Cemetery
Location: Forest Glen, Maryland

18. Funeral director: Daniel E. Cumpston
Address: Silver Spring, Md.

19. Feb. 18 19 47 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17 19 47 at 2:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiner's to Case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac anomaly	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. P. Davenport M. D.
Sub. Medical Exam. for Dr. or other C. O.
Address: Bethesda, Md. Date signed 2-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

01839

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1-18-'47

Hospital, institution, or street address where death occurred:
Suburban Hosp.-8600 Old Georgetown Rd.,

How long in hospital or institution? Since 1-18-'47 Bethesda Md.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5229 5th St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Lillian E. Nelson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
F	W	

6.(b) Name of husband ~~or wife~~ P.E. Nelson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 28, 1900

8. AGE: Years	Months	Days	If less than one day
46	11	9	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Wm F. Risdon

13. Birthplace ? Virginia

MOTHER 14. Maiden name Eleanor Byles

15. Birthplace ? Virginia

16. Informant P. E. Nelson - husb

Address 5229 - 5 st. N. W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?). Date thereof 2/10/47 (month) (day) (year)

Cemetery or crematory Arlington Natl Cem

Location Va

18. Funeral director J. H. Hines Co

Address 2901 - 14 St N W

19. 2/7 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7-'47 1947, at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1/7/Feb/47 to 1/7/Feb/47 and that I last saw h. alive on 1/7/Feb/47

Immediate cause of death	DURATION
(a) Pulmonic Heart Disease	
Mitral Stenosis & Insufficiency	
Due to (b) Aortic Stenosis & Insufficiency ?	
Due to (c)	
Due to (d)	
Other conditions Pulmonary Infarction Bilateral.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Arabon.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles R. T. Holley M.D.
M. D. or other

Address 1801 Eye Wash D.C. Date signed 2/7/Feb/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

01840

Reg. Diat. No. 7160

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 1:42 P.M. 2-10-'47

Hospital, institution, or street address where death occurred:

Suburban Hosp-Bethesda Md.

How long in hospital or institution? since 1:42 P.M. 2-10-'47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 - 6th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs Rosemary O'Day

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
F	W	

6.(b) Name of husband ~~or wife~~ Commie J. O'Day

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1895

8. AGE: Years	Months	Days	If less than one day
51	4	5	..... hrs. ..... min.

9. Birthplace Warren, Pennsylvania (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name (Unknown) Washburn

13. Birthplace (?) (Canada)

MOTHER 14. Maiden name Sarah (Unknown)

15. Birthplace (?) England

16. Informant Husband

Address 511 - 6th St. N.W. Washington DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-13-47 (month) (day) (year)

Cemetery or crematory Cedar Hill.

Location Suitland Md.

18. Funeral director P. J. Saffell.

Address 475 - K St N.W. Wash, D.C.

19. 2/11 1947 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1947, at 10.41 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 10, 1947, to Feb. 10 1947 and that I last saw h.. alive on 4.30 P.M. - 2-10 1947

	DURATION
Immediate cause of death Diabetic coma	2 hrs
Due to Diabetes mellitus	8 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Pulmonary edema Bronchopneumonia Healed apical tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John L. McEwan M.D. (M. D. or other)

Address 29 Newark St. N.W. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16 9-45-15M 4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01841

Reg. Dist. No. 216 /

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 hours

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 22 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3502 16th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American ✓

3. (a) FULL NAME: O'NEILL, John Aloysius

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 16 November 1874

8. AGE: Years	Months	Days	If less than one day
62	2	20	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Postal Clerk, Retired

11. Industry or business: Civil Service

FATHER 12. Name: John O'Neill

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Georgiana Whitney

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. A. Reid

Address: 217 - 19th St. NE Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-10-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Virginia

18. Funeral director: Timothy Dunlop W&R

Address: 641 4 St. NE Washington D.C.

19. 2-6 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 February 19 47, at 6:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Feb. 19 47, to 6 Feb. 19 47 and that I last saw him alive on 6 Feb. 19 47

Immediate cause of death	DURATION
Congestive heart failure	3 days
Due to: Coronary Thrombosis with myocardial infarction	3 days
Due to:	
Other conditions: Generalized arteriosclerosis	years

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: Myocardial infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

23. SIGNATURE: Charles W. Thompson
C. W. THOMPSON, Ltcdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2/14/47

2-25-

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-P)

CERTIFICATE OF DEATH

★ 01842

Reg. Dist. No. 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Jan., 24, 1947

Hospital, Institution, or street address where death occurred:
Suburban Hosp., Bethesda Md.

How long in hospital or institution? since Jan., 24, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. Montgomery Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Homer Payne

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1882

8. AGE: Years	Months	Days	If less than one day
64	10	7	..... hrs. ..... min.

9. Birthplace Loudons Co. Virginia
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name Philip Payne

13. Birthplace Lincoln Virginia

MOTHER 14. Maiden name Offie Perry

15. Birthplace Lincoln Virginia

16. Informant John Payne (brother)

Address Scotland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10, 1947 (month) (day) (year)

Cemetery or crematory Court Home

Location Rockville, Md.

18. Funeral director R. L. Snowden

Address Rockville, Md.

19. 2/10 1947 (Date rec'd by registrar) Jm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4-'47 19 47, at 7 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24 1947 to February 3 1947 and that I last saw h[illegible] alive on February 3, 1947

Immediate cause of death Peritonitis — DURATION 11 days

Due to Postoperative following resection of sigmoid + descending colon

Due to for volvulus of the sigmoid colon

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Volvulus of sigmoid colon Date of op. 1/24/1947

Autopsy results Acute suppurative peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Barbara Moulton M.D.
M. D. or other

Address Suburban Hospital, Bethesda Md. Date signed 2/4/1947

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-12)

CERTIFICATE OF DEATH

01843

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)

State: Pa. County:

City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7509 Newland St.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3. (a) FULL NAME: PETERMAN, Jack Maurice

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 22, 1891

8. AGE: Years	Months	Days	If less than one day
55	2	4	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: Maurice L. Peterman, dec.
13. Birthplace: Pa.

MOTHER
14. Maiden name: Neta Z. Murphy, dec.
15. Birthplace: Pa.

16. Informant: brother: Mr. Richard Peterman
Address: 7509 Newland St., Philadelphia, 28, Pa.

17. removal
(Burial, cremation, or removal. Which?)
Date thereof: 2-26-47 (month) (day) (year)

Cemetery or crematory:

Location: Phila., Penn.

18. Funeral director: Edward Gasch Edward Gasch
Address: 4739 Baltimore Ave., Hyattsville, Md.

19. 2-26 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 February 1947 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 February 1947, to 26 Feb. 1947 and that I last saw h... in alive on 26 February 1947

	DURATION
Immediate cause of death: Uremia	2 weeks
Due to: Pyleonephritis	1 yr.
Due to: Prostatic Hypertrophy	1 yr.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Marked pyleonephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. N. GRANT, Comdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

3/4/47

2-25

2 - 2160 — 2 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

01844

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo - 9 days

Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 6 mo - 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1350 Sheridon St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Price Mrs Anna Mary

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Mr Clinton O Price

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 27, 1871

8. AGE: Years	Months	Days	If less than one day
76	1	1	____ hrs. ____ min.

9. Birthplace: Greenfield Indiana
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Stewart
13. Birthplace: Ind

MOTHER
14. Maiden name: Emma Johnson
15. Birthplace: Mrs

16. Informant: Mrs Margaret Lee Price

Address: 1350 Sheridan St NW.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 3, 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg Md

18. Funeral director: Neal Funeral Home

Address: 4812 Ga Ave NW

19. February 28, 1947 (Date rec'd by registrar) William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28 1947, at 12:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1946, to Feb 28 1947

and that I last saw her alive on Feb 27 1947

Immediate cause of death	DURATION
Uremic State; not due to chron. Interstitial nephritis. Due to:	Terminal
Due to Hypertension, Sec	7 years
Due to Arteriosclerosis, Cause	5 years
Other conditions Nuclear Infarcts of the Brain.	?

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Confirm above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Robert A Hare M.D.
M. D. or other

Address: Takoma Park Md Date signed: 3/5/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01845

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N.C. County:
City or town: Forest City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. #2, Box 261
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: QUEEN, William Russell, S2c USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 5, 1927

8. AGE: Years	Months	Days	If less than one day
19	3	21	hrs. min.

9. Birthplace: N.C. (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: Jacob J. Queen
13. Birthplace: N.C.

MOTHER
14. Maiden name: Daniel,
15. Birthplace: N.C.

16. Informant: father: Mr. Jacob J. Queen
Address: Rt. #2, Box 261, Forest City, N.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3-2-47 (month) (day) (year)
Cemetery or crematory: Baptist Cemetery
Location: Adaiville, N. C. (Rutherford Co.)

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 2-27 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 February 19 47, at 3:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb. 19 47, to 26 Feb. 19 47 and that I last saw him alive on 26 February 19 47

Immediate cause of death	DURATION
Pneumonia, Broncho.	not stated.
Uremia	
Due to Subacute glomerulonephritis	
acute exacerbation of, Cause	
Due to Uremia, Kidney	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

W. A. DINSMORE, Jr. Lt. Cdr. (MC) USN
23. SIGNATURE: M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/6/47

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

01846

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Washington DC County

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5204 - 14th St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war NONE

3. (a) FULL NAME Mr Roland C. Ray

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Married

6.(b) Name of husband or wife Nan C. Ray

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1884

8. AGE: Years	Months	Days	If less than one day
63	—	26	...hrs. ...min.

9. Birthplace Mo. County - Maryland.
(Town, county, and state)

10. Usual occupation Washington Gas Light

11. Industry or business Credit Manager.

FATHER 12. Name Richard Ray.

13. Birthplace Montgomery Co. Md.

MOTHER 14. Maiden name Rebecca Ceskell

15. Birthplace Montgomery Co. Md.

16. Informant Wife

Address ABOVE ADDRESS

17. REMOVAL Date thereof 2/1/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory W. R. Pumphrey Funeral Home

Location Bethesda - Md.

18. Funeral director W. M. Andrew-Pumphrey

Address Bethesda

19. Feb 1 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1947 at 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to Feb 1 1947 and that I last saw him alive on Jan 31, 1947

Immediate cause of death	DURATION
a Infarction of Myocardium due to Coronary Thrombosis	3 wks.
Due to Hypertensive Cardiovascular disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clemens J. Brown M.D.
M. D. or other

Address 45 Carroll Ave Takoma Pk. Date signed Feb 1 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Richard R. Ray
Ryder C. Ray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (114)

CERTIFICATE OF DEATH

01847

216

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/4/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 88 days

Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL BETHESDA MD.

How long in hospital or institution? 88 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Dist. of Columbia County: Washington D. C.

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1513 E. St., S. E. Washington D. C.
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am.

3.(a) FULL NAME: REED, William Browning

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Married

6.(b) Name of husband or wife: Mrs. Ethel Reed

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 4, 1872

8. AGE: Years	Months	Days	If less than one day
74	6	19	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: James Reed
13. Birthplace: England

MOTHER
14. Maiden name: Kate Gosnel
15. Birthplace: Ireland

16. Informant: wife: Mrs. Ethel Reed

Address: 1513 E St., S.E., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-26-47 (month) (day) (year)

Cemetery or crematory: Arlington Nat. Cemetery

Location: Arlington Va.

18. Funeral director: R.A. Mattingly N.I.M.

Address: 131 11th St. S.E. Wash. D.C.

19. 2-23 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 February 19 47, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 November 19 46, to 23 Feb. 19 47 and that I last saw h. im alive on 23 Feb. 19 47

Immediate cause of death	DURATION
Atelectasis Primis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. H. S. Smith, Comdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-23-47

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-e)

CERTIFICATE OF DEATH

01848

Reg. Diat. No. 2181

1. PLACE OF DEATH:

County: Montgomery

City or town: Laytonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution or street address where death occurred:

Gaithersburg R-2

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Laytonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Gaithersburg R-2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Earl B. Richards

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mildred L. Richards

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): April 27 - 1894

8. AGE:

Years	Months	Days	If less than one day
52	9	14	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER

12. Name: Joseph B. Richards

13. Birthplace: Maryland

MOTHER

14. Maiden name: Helen Murphy

15. Birthplace: Maryland

16. Informant: Mildred Lee Richards

Address: Gaithersburg Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: Feb 12 1947 (month) (day) (year)

Cemetery or crematory: Laytonsville Md

Location: Montgomery Co Md

18. Funeral director: Roy W Barber

Address: Laytonsville Md

19. (Date rec'd by registrar) Feb 12 1947 L. D. Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10 19 47, at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 med. Exam Care 19..., to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Fractures of skull	Hours
Due to: Accidental	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 2-10-47

Where did injury occur? Laytonsville (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): Farm

Means of injury: Struck by falling Injured at work? Yes

23. SIGNATURE: Frank J. Broccharts M. D. Dept. med. Examr, M. D. or other

Address: Gaithersburg Md Date signed 2-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-27

2-2180 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (71a)

CERTIFICATE OF DEATH

★ 01849

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

3/6/47

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1438 W Street, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st WW & 2ND WW ✓

3.(a) FULL NAME: ROGERS, Robert Frank,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. R. F. Rogers
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10 June 1899

8. AGE: Years	Months	Days	If less than one day
47	8	17	hrs. min.

9. Birthplace: Tenn.
(Town, county, and state)
10. Usual occupation: Department of Commerce
11. Industry or business:

FATHER
12. Name: Robert B. Rogers dec.
13. Birthplace: Tenn.

MOTHER
14. Maiden name: Alice Walker dec.
15. Birthplace: Ten.

16. Informant: wife: Mrs. R. F. Rogers
Address: 1438 W. St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-3-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia
18. Funeral director: W. W. Chambers L.D.
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 2-28 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 February 19 47, at 10:22 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6 February 19 47, to 27 Feb. 19 47
and that I last saw him alive on 27 February 19 47

Immediate cause of death	DURATION
Cerebral infarct	48 h.
Due to emboli from cardiac mural thrombus	
Due to Coronary thrombosis c	
Other conditions myocardial infarction ant. sept. hemorrhagic	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson C. W. THOMPSON, Lt. Cdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-28-47

2-25

2-2160 — 2-10

01850

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

4403 East West Highway

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Conn. County: Hartford

City or town: Hartford

(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Oakland Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Elizabeth V. Ruby

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Henry Ruby

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Jan. 9, 1884

8. AGE: Years	Months	Days	If less than one day
60	1	5	... hrs. ... min.

9. Birthplace: Hartford Conn (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER — 12. Name: Patrick Heffey

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Catherine Halloway

15. Birthplace: Collinsville Conn.

16. Informant: Mary Doyle

Address: 66 Hitchcock Rd. Watertown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/17/47 (month) (day) (year)

Cemetery or crematory: Mt St Benedict Cem

Location: Bloomfield, Conn

18. Funeral director: The S.H. Hines Co

Address: 2901 14th St N.W. Wash. D.C.

19. 2/15 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1947 at 8 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to Feb 14 1947 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	about 1 day
Due to	
Due to	
Other conditions: Hypertension	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. ...

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Bronhart M.D. (Sept 1946 Exam) M. D. or other

Address: Hartford Conn M.D. Date signed: 2-14-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01851

CERTIFICATE OF DEATH

Reg. Dist. No. 2170

1. PLACE OF DEATH:
County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hours
Hospital, institution, or street address where death occurred: The Montgomery County General Hospital
How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Grace C. Ruby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Widowed

6.(b) Name of husband or wife John Harbin Ruby
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 26, 1857

8. AGE: Years	Months	Days	If less than one day
90 90	0	18	..... hrs. ..... min.

9. Birthplace Ralston Texas
(Town, county, and state)
10. Usual occupation Retired H.W.
11. Industry or business
FATHER 12. Name James Elliott Carnes
13. Birthplace Chambersburg Pa
MOTHER 14. Maiden name Fanny Thompson
15. Birthplace Lexington Ky.
16. Informant Hosp. Records.
Address
17. ~~Cremation~~ Burial Date thereof Feb 14 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory ~~Oakwood~~ Hill
Location ~~Guilford, Md.~~ Houston, Texas.
18. Funeral director Warren E. Pumphrey
Address Silver Spring Md.
19. 2-11-1947 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1947, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1947, to Feb. 11 1947
and that I last saw h.e.r alive on February 11, 1947

	DURATION
Immediate cause of death Diabetic Coma	36 hrs.
Due to Diabetes	8 yrs.
Due to	
Other conditions General arterio sclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas B Tumbleson M.D., or Other
Address Sandy Spring, Md Signed 2-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-55

01852

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124b)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Falls Church
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. #2
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: SAUNDERS, Richard Otto Earl, QMSgt. USMCRet. Inact. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Hazel C. Saunders
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1881

8. AGE: Years 65 | Months 5 | Days 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Marine Corps Hdqtrs., (Government)
11. Industry or business: Arlington Annex, Arl., Va.

FATHER
12. Name: Otho A. Saunders dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: Lela A. Rouzie dec
15. Birthplace: Va.

16. Informant: wife: Mrs. Hazel C. Saunders
Address: Falls Church, Va., Rt. #2

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-1-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: Ives Funeral Home
Address: 2847 Wilson Blvd., Arl., Va.

19. 2-26 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 February 19 47, at 10:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 February 19 47, to 26 February 19 47 and that I last saw h... im... alive on 26 February 19 47

	DURATION
Immediate cause of death: Hemorrhage, esophageal	2 days
Due to: cirrhosis of liver	8 months
Due to:	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: not permitted
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Fleck, R. L. FLECK, Lt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/4/47

2-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01853

Reg. Dist. No. 2121

1. PLACE OF DEATH:
County Montgomery
City or town Dickerson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Poolesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles B. Sellman

3.(b) Social Security Number 218-14-2098

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Sarah G. Sellman
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Jan 22 1881

8. AGE: Years	Months	Days	If less than one day
66	1	6	hrs. min.

9. Birthplace Poolesville, Monty Co, Md
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name Chas Sellman
13. Birthplace Barnesville, Md
MOTHER 14. Maiden name Lucy Veirs
15. Birthplace Poolesville, Md
16. Informant Mrs Chas Sellman
Address Poolesville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar-3-1947 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville, Md
18. Funeral director William B Hilton
Address Barnesville, Md
19. March 2 1947 (Date rec'd by registrar) Mrs. C. C. Hilton by mw. C.D.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 19 47, at 4:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. Med. Exam Case 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Coronary occlusion	Several days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brashear M.D. M. D. or other
Address Gaithersburg Md. Date signed 3-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-2120 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

01854

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days.
Hospital, Institution, or street address where death occurred:
Suburban Hosp. Bethesda, Md.
How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Shelton, Henry.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	married

6.(b) Name of husband or wife Maggie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1888

8. AGE: Years	Months	Days	If less than one day
58	11	9	..... hrs. ..... min.

9. Birthplace Howard County, Virginia
(Town, county, and state)
10. Usual occupation mechanic
11. Industry or business
FATHER 12. Name Blackwell Shelton
13. Birthplace Virginia
MOTHER 14. Maiden name Margaret Thomas
15. Birthplace Virginia
16. Informant Mrs Maggie Shelton
Address Lincoln Park, Rockville, md
17. Burial (Burial, cremation, or removal? Which?) Date thereof Feb. 4, 1947 (month) (day) (year)
Cemetery or crematory Lincoln Park,
Location Rockville, md
18. Funeral director R. L. Snowden
Address 246 N. Wash. St. Rockville
19. 2/4 1947 Wm E Jules Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1st 1947 at 3.05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/17 1947 to Feb 1st 1947 and that I last saw him alive on Feb 1st 1947

	DURATION
Immediate cause of death Hemorrhage	
Due to Stomach	
Due to Carcinoma of Pylorus and of Stomach	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE O E Hawks M. D. or other
Address Boyds Md Date signed 2/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Diat. No. 01855 2160

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 2-15-47

Hospital, institution, or street address where death occurred:
Suburban Hosp. 8600 Old Georgetown Rd.

How long in hospital or institution? Since 2-15-47 Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. no. 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr Clarence Shipley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, ~~or divorced~~
M	W	

6.(b) Name of husband or wife Dec.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1875

8. AGE: Years	Months	Days	If less than one day
71	5	19	..... hrs. ..... min.

9. Birthplace DAISY, MD. (Town, county, and state)

10. Usual occupation STONE MASON

11. Industry or business

FATHER 12. Name JOHN ROBERT SHIPLEY

13. Birthplace HOWARD COUNTY, MD

MOTHER 14. Maiden name MARY CATHERINE HAGER

15. Birthplace MONTG. COUNTY, MD.

16. Informant JOHN ROBERT SHIPLEY

Address GERMANTOWN, MD.

17. REMOVAL Date thereof 2/26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory SALEM CHURCH

Location CEDAR GROVE MD

18. Funeral director ROY W. BARBER

Address LAYTONSVILLE. MD.

19. 2/26 1947 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1947 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to 26 Feb 1947 and that I last saw him alive on 26 Feb 1947

Immediate cause of death	DURATION
HYPERTENSIVE CARDIO VASCULAR DISEASE	UNKNOWN
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert E. DeLauter, M.D.
M. D. or other
Suburban Hospital
Address Bethesda, Md. Date signed 26 Feb 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

Reg. Dist. No. 01856 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Florence E. Simms

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 22, 1916

8. AGE: Years: 30 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Scotland, Md
(Town, county, and State)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Charles Dorsey
13. Birthplace: Md.

MOTHER
14. Maiden name: Rosie Cooper
15. Birthplace: Scotland, Md.

16. Informant: Rosie Simms
Address: Rockville, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 24 1947 (month) (day) (year)
Cemetery or crematory: Lincoln Park
Location: Rockville, Md.

18. Funeral director: Robert L. Snowden
Address: Rockville, Md.

19. 2-24 1947 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 1947, to Feb. 20 1947, and that I last saw h[illegible] alive on Feb. 18 1947.

Immediate cause of death	DURATION
Lobar pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. W. Hartley M.D.
M. D. or other
Address: Rockville, Md Date signed: 2/22/47

1-35

Evidence for change of year of birth is shown on Circ 7/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

★ 01857

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: NORBECK, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: NORBECK
(If outside city or town limits, write RURAL and give nearest town)

Street No.: MANOR CLUB ESTATES
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MRS. MARY S. SLICER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W.

6.(b) Name of husband or wife: HENRY

6.(c) If alive, give age: 95 years

7. Birth date of deceased (mo., day, yr.): JAN 15 1852

8. AGE: Years: 96 Months: 0 Days: 27 If less than one day: hrs. min.

9. Birthplace: PETERSBURG, VIRGINIA
(Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER
12. Name: William PRITCHARD
13. Birthplace: VIRGINIA

MOTHER
14. Maiden name: MARY SIGOURNEY
15. Birthplace: VIRGINIA

16. Informant: MR T. O. PARRACK

Address: MANOR CLUB ESTATES.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: FEB 15 47 (month) (day) (year)

Cemetery or crematory: BEDFORD

Location: BEDFORD, VIRGINIA

18. Funeral director: Jas Gamble & Son

Address: 766 Pa. Ave. N.W. WASH. D.C.

19. Ret. 2-17 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1947, at 8 50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946, to February 1947

and that I last saw h alive on Feb 14 1947

Immediate cause of death	DURATION
Heart failure due to old age	
Due to	
Due to	
Other conditions: None.	

(Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank D. Keeler M. D. or other

Address: 8248 Georgia Ave. Silver Spring Md. Date signed: Feb 17, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-33-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (154)

CERTIFICATE OF DEATH

01858

Reg. Dist. No. 2161

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? three hours
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2901 1st St., S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SMITH, Sandra (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-9-47

8. AGE:

Years	Months	Days	If less than one day
			3 hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Archie Elmer Smith
13. Birthplace: Calif.

MOTHER
14. Maiden name: Cathrine Bishop
15. Birthplace: Kansas

16. Informant: Mr. Archie E. Smith
Address: 2901 1st St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2-11-47 (month) (day) (year)
Cemetery or crematory: Geo. Wash., Memorial
Location: Hyattsville, Md.

18. Funeral director: W. W. CHAMBERS W A MacLear
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 2-10 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 Feb. 19 47, at 8:05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb. 19 47, to 9 Feb. 19 47
and that I last saw her alive on 9 Feb. 19 47

Immediate cause of death	DURATION
Prematurity	
Due to delivery at 5½ months	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: PAUL PETERSON, Capt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2/15/47

2-25

2-2160 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

01859

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2901 1st St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: SMITH, Wanda (n)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2 - 9 - 47

8. AGE: Years	Months	Days	If less than one day
			3 hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Archie Elmer Smith
13. Birthplace: Calif.

MOTHER
14. Maiden name: Catherine Bishop
15. Birthplace: Kansas

16. Informant: fa: Mr. Archie E. Smith
Address: 2901 1st St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2-11-47 (month) (day) (year)

Cemetery or crematory: Geo. Wash., Memorial

Location: Hyattsville, Md.

18. Funeral director: W. W. CHAMBERS W. A. MacLeod

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 2-10 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 Feb. 1947, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb. 1947, to 9 Feb. 1947 and that I last saw her alive on 9 Feb. 1947

Immediate cause of death	DURATION
Prematurity	
Due to: delivery at 5½ months.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: PAUL PETERSON, Capt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

3/15/47

2-25

2-2160 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01860

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2/18/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 225 N. Thomas Street
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st W.W.

3.(a) FULL NAME: SNIDER, Robert "H"

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 2, 1881

8. AGE: Years	Months	Days	If less than one day
65	8	10	... hrs. ... min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Retired from Government

11. Industry or business:

FATHER
12. Name: Robert P. Snider
13. Birthplace: Ohio

MOTHER
14. Maiden name: Nellie Frances Phillips
15. Birthplace: Ohio

16. Informant: bro: Mr. Murray F. Snider

Address: 1219 Delafield Place, N.W., Wash., D.C.

17. cremation (Burial, cremation, or removal. Which?) Date thereof 2-13-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Washington, D. C.

18. Funeral director: Deal Funeral Home R.E.W.

Address: 4812 Georgia Avenue, N.W., Wash., D.C.

19. 2-12 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 February 1947, at 6: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 February 1947, to 12 Feb. 1947 and that I last saw him alive on 12 February 1947

Immediate cause of death: Generalized Carcinomatosis — DURATION: 1 year

Due to: Carcinoma of the bladder

Due to:

Other conditions: Myocardial infarction — 1 wk

Cirrhosis of liver. — years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Carcinoma of bladder, Myocardial infarct, Cirrhosis of liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson C. W. THOMPSON, Lt. Cdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-12-47

2-25

2-2160 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

01861 MV

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
Suburban Hosp. Bethesda md
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Jaispar Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edward L. Stock Sr.

3.(b) Social Security Number: 212-16-9102

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mildred K Stock
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec 12 1873

8. AGE: Years	Months	Days	If less than one day
73	1	20	....hrs. ....min.

9. Birthplace: Oil City Pa
(Town, county, and state)
10. Usual occupation: heating engineer
11. Industry or business:
FATHER 12. Name: Charles Stock
13. Birthplace: N.Y.
MOTHER 14. Maiden name: Laura Carpenter
15. Birthplace: N.Y.
16. Informant: Mary Stock
Address: Rockville md R.2
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 5, 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D. C.
18. Funeral director: Wm Reuben Humphrey
Address: Bethesda, Maryland
19. 2/4 1947 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2 1947, at 9:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1946, to 1947, and that I last saw h... alive on ... 1947

Immediate cause of death	DURATION
Inter-cranial hemorrhage	30 hrs
Due to: fracture of skull	
Due to: auto accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 2-1-47
Where did injury occur? Near Rockville Monty md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto accident Injured at work? No

23. SIGNATURE: Frank J. Bosehart M. D. M. D. or other
Address: Gaithersburg md Date signed: 2-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-21)

01862

CERTIFICATE OF DEATH

Reg. Dist. No. 7140

1. PLACE OF DEATH:

County: Montgomery

City or town: Cloverly Route 2, Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Cloverly
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____ Route 2, Silver Spring.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Granville Jackson Thompson
Granville Jackson Thompson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ethel Priest Thompson

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): September 1, 1876

8. AGE:

Years	Months	Days	If less than one day
70	5	7	____ hrs. ____ min.

9. Birthplace: Ednor Montg. Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Andrew Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Harding
15. Birthplace: Maryland

16. Informant: Mrs. Ethel Priest Thompson
Address: Cloverly, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-11-1947 (month) (day) (year)

Cemetery ~~or crematory~~: Burtonsville Union

Location: Burtonsville, Montg. Co. Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. 2-11 (Date rec'd by registrar) 1947 Josephine McSherry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1947, at 7:55p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945, to February 8 1947

and that I last saw him alive on February 8 1947

Immediate cause of death	DURATION
Bilateral bronchopneumonia with pulmonary edema	24 hrs.
Due to: Hemiplegia - right side with aphasia	2 yrs.
Due to: Arteriosclerosis with hypertension	3+ yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op. ------

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work? ____

23. SIGNATURE: [signature] M. D. or other

Address: Silver Spring, Maryland Date signed: 2/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age shown on File #109-3/20/47-B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

01863

CERTIFICATE OF DEATH

Reg. Dist. No. 2 / 10

1. PLACE OF DEATH:
County: Montgomery
City or town: Near Damascus, on Cedar Grove Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime in this vicinity
Hospital, institution, or street address where death occurred:
R. F. D. Germantown
How long in hospital or institution? At home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Between Damascus & Cedar Grove
(If ontside city or town limits, write RURAL and give nearest town)
Street No. R. F. D. Germantown, Maryland.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Garrett Webster Watkins

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Vertie Mullinix Watkins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 1871

8. AGE: Years 75 ~~74~~ | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Cedar Grove, Maryland.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: Noah Watkins
13. Birthplace: Montgomery County, Maryland.

MOTHER
14. Maiden name: Julia Linthicum
15. Birthplace: Montgomery County, Maryland

16. Informant: Vertie A Watkins
Address: R.F.D. Germantown. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25 1947 (month) (day) (year)

Cemetery or crematory: Salem
Location: Cedar Grove M.E.

18. Funeral director: Roy W. Barber
Address: Laytonsville, Maryland.

19. Feb 25 1947 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20, 1947, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 1964 to February 20, 1947 and that I last saw him alive on Feb. 20, 1947 1947

Immediate cause of death	DURATION
Cerebral thrombosis	10-23-46
Terminal uremia	
Due to Cerebral arteriosclerosis	? yrs.
Hypotension.	
Due to Generalized arteriosclerosis ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. McKendree Boyer, M.D.
M. McKendree Boyer, M.D. or other
Address: Damascus, Maryland. Date signed: 2-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

01864

2411 N. Charles St., Baltimore (46-27)

CERTIFICATE OF DEATH

Reg. Dist. No. 2236

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9139 Sligo Creek Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Nannie Alice White

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~: PERCY H
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 20, 1864

8. AGE: Years: 82 | Months: 6 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Honeygrove, Texas
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Samuel Erwin
13. Birthplace: Mississippi

MOTHER
14. Maiden name: Elizabeth Drennon
15. Birthplace: Texas

16. Informant: Washington Sanitarium Records
Address: Takoma Park, Maryland

17. Removal + Burial
(Burial, cremation, or removal. Which?)
Date thereof: 2-5-47 (month) (day) (year)

Cemetery or crematory:
Location: HONEY GROVE, FANNIN CO. - TEXAS

18. Funeral director: Ware & Pumphrey
Address: SILVER SPRING, MD.

19. Feb 5 1947
(Date rec'd by registrar)
J. Walter Dodd
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5 1947, at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1947, to Feb 5, 1947 and that I last saw her alive on Feb 4 1947

	DURATION
Immediate cause of death: Hypertensive Heart disease	1 year +
Due to: Arteriosclerosis	10 yrs +
Due to: Carcinoma of transverse colon; Senility	2 yrs +
Other conditions: Fibroid tumor of uterus (Include pregnancy within 3 months of death)	3 yrs +

Major findings of operation: Annular Carcinoma of transverse Colon; fibroid ut. Date of op. Jan 27, 1947
Autopsy results: Refused
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Chas A. Calvert M.D.
Address: 7894 Ga Ave., S.S. Md. M. D. or other
Date signed: 2-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

01865

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Jan. 31, 1947
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 922 Heron Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DANIEL MOORE WHITNEY

3.(b) Social Security Number: 018-07-4780

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of ~~husband~~ wife: Elsie M. Whitney
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1876

8. AGE: Years	Months	Days	If less than one day
70	3	22	..... hrs. ..... min.

9. Birthplace: Maine (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Levi L. Whitney
13. Birthplace: Maine
MOTHER 14. Maiden name: Ellen Moore
15. Birthplace: Maine
16. Informant: Mrs. Nathaniel White, daughter
Address 922 Heron Drive, Silver Spring, Md.
17. Shipment & burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10, 1947 (month) (day) (year)
Cemetery ~~xxxxx~~ Bell Park Cemetery, Natick,
Location Middlesex County, Massachusetts
18. Funeral director: Warner E. Pumphrey
Address Silver Spring, Maryland
19. 2/9 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947, at 3:35 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1946 to Feb. 8 1947 and that I last saw him alive on Feb. 8 1947

Immediate cause of death	DURATION
CEREBRAL THROMBOSIS	Dec. 2, 1946
Due to	
Due to	
Other conditions: generalized arterio sclerosis; hypertension (Include pregnancy within 3 months of death)	

Major findings of operation: confirmation of above
Date of op. 2-9-47
Autopsy results: same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Marion Burkhead M.D. M. D. or other
Address 9601 Sutton St. Silver Spring, Md. Date signed 2/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

01866

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

Reg. Dist. No. 2136

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
None
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 222 West Montgomery Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mary Albert Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Walter A.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14 1882

8. AGE: Years	Months	Days	If less than one day
64	10	12	hrs. min.

9. Birthplace: Rockville Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Charles Albert
13. Birthplace: Rockville Md.
MOTHER 14. Maiden name: Martha Wilson Stonestreet
15. Birthplace: Rockville Md.
16. Informant: Walter A. Williams
Address: Rockville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/25/47 (month) (day) (year)
Cemetery or crematory: Rockville Union Cem.
Location: Rockville Md.
18. Funeral director: Wm. H. Runyon
Address: Rockville Md.
19. 2-26 1947 (Date rec'd by registrar) Betty Jane Snyder (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 1947, at 3 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1928 19 to Feb. 26 1947
and that I last saw h.. alive on Feb. 25 — 1947.

Immediate cause of death	DURATION
Cerebral vascular accident, probably thrombosis	12 days
Due to: Hypertension & arteriosclerosis	5 years
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm. H. Smithcum M.D.
M. D. or other
Address: Rockville, Md. Date signed 2/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

CERTIFICATE OF DEATH

01867

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/3/47

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1218 12th St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd WW ✓

3.(a) FULL NAME: WILLIAMS, Harry (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Lucy Williams
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12 Sept. 1903

8. AGE: Years	Months	Days	If less than one day
43	5	14	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: unknown
11. Industry or business:
FATHER 12. Name: Williams, dec.
13. Birthplace: unknown
MOTHER 14. Maiden name: Nora (maiden name unknown)
15. Birthplace: unknown
16. Informant: wife: Mrs. Lucy Williams
Address: 1218 12th St., N.W., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof 3-1-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. W. Chambers
Address: 1400 Chapin St., N. W., Wash., D.C.
19. 2-26 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 February 1947, at 4:30A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Deputy Medical Examiner Case 19 47
and that I last saw h[illegible] alive on [illegible] 19 47

Immediate cause of death	DURATION
Coronary occlusion	about 1 hour
Due to Natural causes — coronary occlusion his injury having had nothing whatsoever to do with the cause of his death.	
Automobile accident. Inj. S.R.	
Other conditions Fracture 2nd cervical Vertebrae	1 mo.

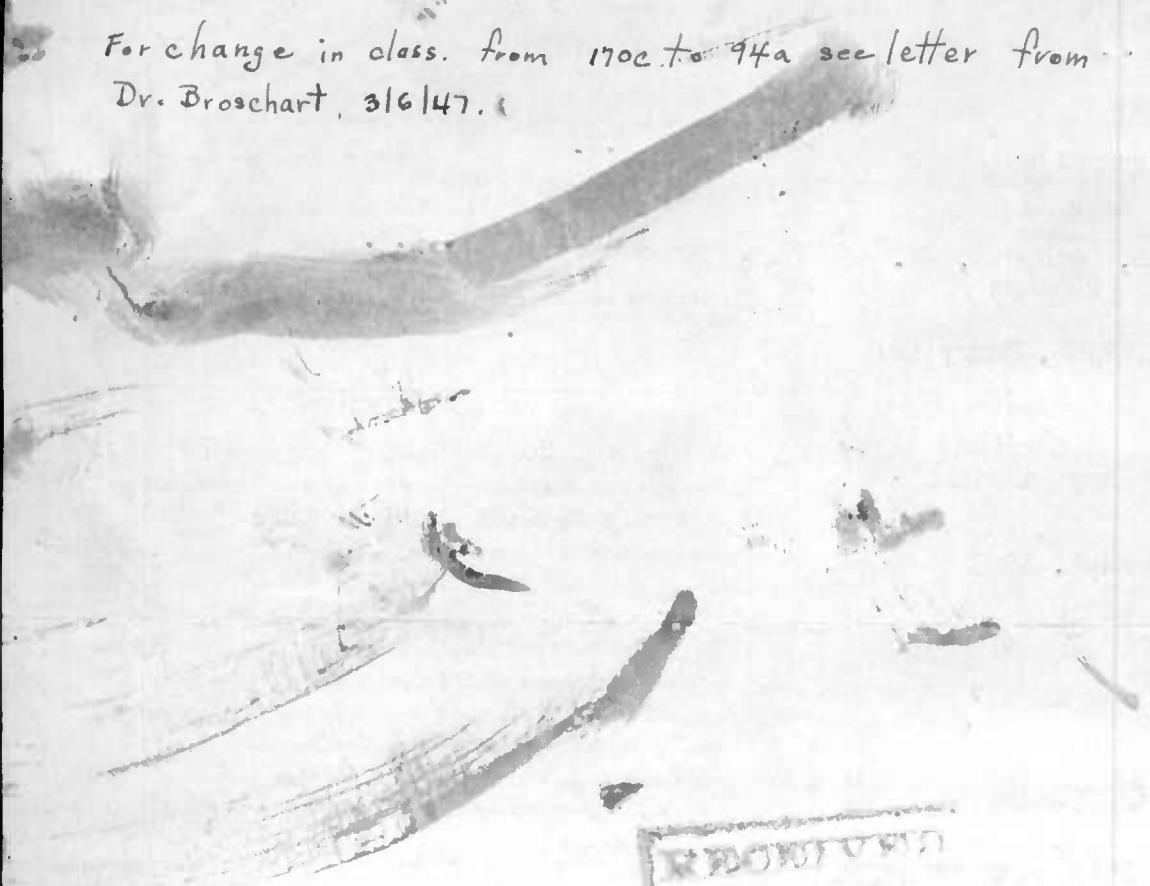
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of Jan. 28, 1947
Where did injury occur? Faulkner, Chas. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Automobile accident. Injured at work?

23. SIGNATURE: Frank J. Broschart
Frank J. Broschart, M.D.
Mont. Co., Medical Examiner M. D. or other
Address: Gaithersburg, Md. Date signed

For change in class. from 170c to 94a see letter from Dr. Broschart, 3/6/47.



2-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

01868

CERTIFICATE OF DEATH

Reg. Diat. No. 2230

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 wks.
Hospital, Institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 2 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County —
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 725 Fern Place, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME WITMER, MRS. ELLEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Cary Witmer
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) December 31, 1872

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
74	1	24		

9. Birthplace Dover, York County, Pennsylvania (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business —

FATHER
12. Name Michael Link
13. Birthplace —

MOTHER
14. Maiden name Sarah Miller
15. Birthplace Perry County, Pennsylvania

16. Informant Records – Washington Sanitarium and Hospital
Address 700 Carroll Avenue, Takoma Park, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 27, 1947. (month) (day) (year)
Cemetery or crematory Greenmount Cemetery.
Location York, Penna.
18. Funeral director Arthur Walters.
Address 254 Carroll St. N.W. Takoma Park D.C.
19. Feb. 26 1947 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1947 at 9 50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to February 24 1947 and that I last saw her alive on February 24 1947

Immediate cause of death	DURATION
Bile peritonitis	3 mos.
Generalized	
Due to Leakage from gall bladder	3 mos.
Due to	
Other conditions Bilateral hydrothorax	1½ weeks

(Include pregnancy within 3 months of death)

Major findings of operations cholecystectomy and choledochostomy Date of op. Dec. 20, 1946
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Herman I. Slatt M.D.
M. D. or other
Address 1008 Highland St. Ark. Va. Date signed 2-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1 - 35

01869

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. -216/

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1758 K Street, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

131a

3. (a) FULL NAME: WOOD, Kate Corcoran

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife: Col. Thomas N. Wood
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 October 1862

8. AGE: Years	Months	Days	If less than one day
84	3	28	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: C. N. Thorn (dec)
13. Birthplace: N.H.

MOTHER
14. Maiden name: Sarah K. Cochrane
15. Birthplace: Washington, D. C.

16. Informant: Mrs. Robert Dunlap
Address: 1758 K St., N.W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24 1947 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Virginia

18. Funeral director: Joseph Gawler Sons R.E. Hucks R.F.
Address: 1756 Penn. Ave. NW, Washington, D. C.

19. 2-21 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 February 1947, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 February 1947, to 21 February 1947 and that I last saw her alive on 21 February 1947

	DURATION
Immediate cause of death: Congestive heart failure	
Due to: Arteriosclerotic heart disease and	
Due to: renal failure	
Other conditions: Emphysema of the gall bladder. Nephrosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. C. PARKER, Comdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/7/47

2-25

2-2160 - 2-18

01870

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21-60

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery County
City or town: Rock Creek Forest, Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, Institution, or street address where death occurred: -----
How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rock Creek Forest, Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8104 - Larry Place
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3.(a) FULL NAME: MARIE CATHERINE ZIMMERMAN

3.(b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Johnston R. Zimmerman
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 30, 1888

8. AGE: Years	Months	Days	If less than one day
58	5	9	..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: -------- McEwen
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Margaret McEwen
15. Birthplace: Washington, D.C.

16. Informant: Mr. Johnston R. Zimmerman
Address: 8104-Larry Pl., Rock Creek Forest, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: February 11/47 (month) (day) (year)
Cemetery or crematory: Congressional Cemetery
Location: Washington, D.C.
18. Funeral director: Martin W. Hysong Co.
Address: 1300 - N St. N.W., Washington, D.C.
19. 2/9 (Date rec'd by registrar) 1947 Wm E Gobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8, 1947, at 9:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8, 1947 to Feb. 8, 1947 and that I last saw her alive on Feb. 8, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Hypertensive Cardio-Vasc. renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Philip H. Varner M. D. or other
Address: 7822 Conn. Ave., Chevy Chase, Md. Date signed: 2/11/47

Dr. Broschart, Medical Examiner, notified and will approve.
11:10 P.M.
Feb. 8/47